Agenda Item 5 – Chief Executive Officer's Report

Appendix A – Events and meetings attended by the ICB CEO and Chair on behalf of the ICB.

4 October	**Integrated Care Non-Executives and Executives and Bedfordshire Hospitals NHS Foundation Trust Board to Board** The purpose of the meeting was to develop a shared understanding of Trust plans and how they align to and can be supported by system plans; to share expectations of the Bedfordshire Care Alliance and how it will work with system and place partners.
5 October	**Minister Markham Panel with ICS Leaders** The Chief Executive Officer was asked to present to the Department of Health and Social Care as part of ICS week, this was hosted by Lord Markham, Minister of Health in the Lords, and Matthew Styles the Director General of the Department. It was a good opportunity to showcase the good work BLMK is doing.
9 October	**Meeting with Andrew Selous MP** The Chief Executive Officer met with Andrew Selous MP to provide an update on Leighton Buzzard, as part of a commitment to provide progress updates every six weeks.
1 October	**ICB Mental Health Meeting with Claire Murdoch** The Chief Executive Officer attended a seminar hosted by the National Director for Mental Health, NHS England, to discuss planning mental health services for the future.
12 October	**Health Services Journal (HSJ) Summit in Liverpool** The Chief Executive Officer attended and led a panel on partnership working and children's services.
15 October	**Love Luton RunFest** The Chief Executive Officer successfully completed a 5k run with other colleagues from the ICB and from Luton Borough Council. The team are looking to support similar events across all Places.
16 October & 27 November	**Meeting with Andrew Selous MP** The Chief Executive Officer met with Andrew Selous MP to provide an update on Leighton Buzzard, as part of a commitment to provide progress updates every six weeks.
16 October	**ARC (Applied Research Collaboration) Population Health Data Advisory Panel** This meeting was hosted by the Applied Research Collaboration and was attended by the Chief Executive Officer and Chair to gain an update on the ARC consultation: 'Responding to future research needs' and next steps.
17 October	**East of England Systems Learning Network** Attended by the Chair, Dr Rima Makarem.

19 October	**East London NHS Foundation Trust Annual Staff Awards** This event was attended by Chief Transformation Officer to represent the ICB in celebrating the achievements of employees.
19 October	**NHS East of England Chief Executive Event** Attended by the Chief Executive Officer, the event focussed on innovation, with a presentation by the Chief Executive of the Eastern Academic Health Science Network (AHSN) and group discussions on current key issues through an innovation lens.
25 October	**NHS Confederation Spotlight on Measuring Outcomes** With the Chair as a guest presenter the event was attended by members of the ICB Executive Team.
25 October	**Mayor Tom Wootton, Laura Church, Chief Executive of Bedford Borough Council and Lorraine Sunduza, Interim Chair of East London NHS Foundation Trust** The Chief Executive Officer attended a meeting to discuss planning for future mental health provision in Bedford Borough.
30 October	**Faith Leaders in Luton**
31 October	**Gary Sweet, Chief Executive Officer of Luton Town Football Club** The Chief Executive Officer and Chair met Mr Sweet at Kenilworth Road to discuss how the ICS can harness the positive influence of football in the local community.
2 November	**Peer Review Interview** Attended by the Chief Executive Officer to support the Bedford Borough Council Peer Review.
2 November	**Transforming Performance and Engagement through a strengths approach to management** The Chief Executive Officer attended an event that focussed on the benefits of a strengths approach to management in resolving keys issues such as retention, morale and productivity in public sector organisations.
7 November	**Health Hubs Discussion - Central Bedfordshire with Councillors Adam Zerny, Hayley Whitaker and Rebecca Hares** The Chair, Chief Executive Officer and Chief Transformation Officer attended this meeting which looked at future provision and making more use of existing and planned estate in Central Bedfordshire Council (CBC).
8 November	**NHS England Leadership Event in London** Attended by the Chief Executive Officer. The event, hosted by Sir David Behan and Amanda Pritchard, included a federated data plat forma demonstration and discussions on maternity and neonatal delivery plan, NHS Impact and leadership in paediatric mental health.
9 November	**Specialised Commissioning Workshop, Fulbourn**

9 November	**Leighton Buzzard Outline Business Case Engagement Event** The purpose of the event was to establish resident views into the Outline Business Case process. Presented by Deputy Chief of System Assurance and Corporate Services and Associate Director of System Estates and attended by an audience 40+ including Patient Participation Group representatives, organisations from the Voluntary, Community and Social Enterprise sector and politicians.
10 November	**Community Interest Luton Awards** Attended by the Chief Executive Officer and a small group of ICB staff. The ICB sponsored the Caring Hero Award and the Chief Executive Officer had the privilege of presenting the award to Dr Talib Abubacker.
13 November	**Introduction Meeting - Alistair Strathern MP** Chief Executive Officer and Chair met with the recently appointed MP for Mid Bedfordshire.
16 November	**Bedfordshire Hospitals Estates Master Plan Meeting** Attended by the Chair, Chief Executive Officer, Chief Finance Officer and Chief Transformation Officer to discuss future estates plans with David Carter and Richard Sumray.
22 November	**ICB Executive Team Open Space Session Led by the Institute of Health Improvement (IHI)** The session was facilitated by Diane Murray, Institute of Health Improvement and Hugh McCaughey, IHI Faculty (former National Director of Improvement for NHS England and former Chief Executive of South Eastern Health and Social Care Trust) and used case studies to share experiences, discuss lessons learned and plan how to engage colleagues in improvement.
24 November	**Joint ICB/ICP Strategic Early Years Seminar**
28 November	**ICS Network Conference in London** The event was attended by the Chief Executive Officer and Chair and focussed on delivering the four core purposes of ICSs.
29 November	**Executive to Executive with Central Bedfordshire Council** The Executive Teams of the two organisations discussed joint working in relation to key delivery areas.
7 December	**Bedfordshire Data Summit hosted by Bedfordshire Fire and Rescue Service** Colleagues from the ICB attended a collaboration event which focussed on the benefits of data sharing, overcoming barriers and identifying next steps.

Recommendations

Our recommendations fit within four groups. These are **access, communication, representation** and **cultural competency**. They are grouped in two time-frames. The first is short-term changes which can be actioned over the next one to two years.

These changes will allow residents to see that things are changing for the better. The second category of recommendations are longer-term and will change how the health and care system operates in a deeper and more fundamental way. It's important to note that some work has already taken place in some of the areas outlined in the recommendations – but greater focus and momentum is essential.

How we developed the recommendations

Overall it is the clear ambition of this report to make recommendations which, when taken together, spur system leaders to respond radically in designing and delivering their approach to health inequalities.

The recommendations have been developed by the Denny Review Steering Group based on the published evidence and the views of residents.

Further work is required with community pharmacists, dentists, optometrists, NHS Trusts and local authorities and the VCSE sector to determine how the recommendations can be implemented and performance monitored, and to define the crucial role provider collaboratives can play. These organisations will need to come together to determine whether the recommendations are delivering the impact called for by residents and healthcare professionals.

Short-term change

Recommendations that can be implemented in the shorter term, which will help to make an immediate difference to the experience of residents over the next one to two years.

Insight area	Recommendation
Access	Contracts for new products and services should rigorously apply the Accessible Information Standards and the Equality Act so that they meet the needs of all residents and staff members, for example when purchasing personal protective equipment (PPE). This includes ensuring that residents are asked about or offered information in a format or language that they can understand. Consideration should be made to help prevent residents being excluded from services due to barriers which include a lack of access to digital technology.
	An urgent review of all health and care premises should be undertaken to ensure disability access is always available.
	Hearing loops should be installed across all healthcare establishments and staff should be provided with training to ensure they are always functional.
	Hospital trusts and primary care should undertake a review of what, if any, interpreter and translation services are available and accessible to ensure patient needs are being met.
	GP practices should review their procedures to stop residents being wrongly stopped from registering, potentially denying them access to essential health services. Practices must ensure they meet Primary Medical Care Policy and Guidance, and that national policy is uniformly and rigorously applied.

Insight area	Recommendation
Communications	Residents and partners to come together to co-develop a communications campaign to support people to explain how the health and care system works, and how to navigate it, with a particular focus on supporting minority groups. This campaign should include regular updates on the implementation of the Denny Review, and, where relevant, have a gender focus too for specific men's/women's issues highlighted.
	Urgent review of all communications and marketing materials to ensure that imagery and language is culturally appropriate and reflects the different communities in BLMK.
	Collaborate to implement a universal translation service for BLMK that provides consistency across all NHS provider organisations. This should be achieved by undertaking an urgent review of all translation services provided in BLMK's health and care sector to ensure it complies with Accessible Information Standards. This should mean that interpreters are always available, that there is consistency across primary and secondary care services, and that British Sign Language (BSL) interpreters are included in the list of available languages.

Insight area	Recommendation
Representation	Support GP practices to ensure that Patient Participation Groups, as required within contracts, are in place and receive sufficient investment.
	BLMK Integrated Care System should set out how its future engagement work is shared, to avoid duplication of effort and maximise impact.
	Training for health and care professionals and those people involved in community connector roles in Quality Improvement (QI) and co-production. This will help to embed a more person-centred approach, so that residents' needs are at the heart of any solution.
	Support the healthcare system to be more resilient for future pandemics. Consider the impact they can have on the workforce, specifically people from ethnic minority backgrounds. Within this, look at how PPE is distributed to meet the needs of a diverse health and care workforce.
	Senior leadership mentoring scheme introduced within NHS organisations for people from ethnic minority backgrounds to help improve diversity management across the ICS. Encourage greater diversity within management, and greater diversity on interview panels.
Cultural competency	Training rolled out to all health and care settings to support with language, and understanding the needs of residents, including different ethnicities, those with physical and learning disabilities, and LGBT+ people. This will help to address perceptions of cultural bias / racism which was a consistent theme within community engagement and can build on current patient participation.
	Greater investment in services that are working well, such as local sexual health services.

Long-term change

Recommendations which make larger, more fundamental changes to how healthcare is delivered, which residents will see the effect of over the next three to five years.

Insight area	Recommendation
Access	Consider extending the service hours available in primary care to evenings and weekends for those unable to attend day-time appointments. Also include access to female-only clinics to support people from different faiths and cultures, and victims of male violence.
	Ensure that residents who would prefer to access some healthcare services anonymously are able to do so. This could be done, for example, through more services, or a greater proportion of them, being provided digitally.
	Work with the VCSE to fund Access Champions to support people who are unsure how to navigate health and care services or have additional needs to access appointments, or other services to support their health and wellbeing.
	Establish an end-to-end service for long COVID.
Communication	Based on the findings of the review of interpretation services, ensure that there is a consistent service across health and care and that translated materials are available in line with legal duties.
Representation	Improve integration of housing, hospitals and mental health support in homeless shelters.
	1 in 4 black men will get **prostate cancer** in their lifetime. Black men are more likely to get prostate cancer than other men, who have a 1 in 8 chance of getting prostate cancer, according to Prostate Cancer UK. The ICB should work with **researchers** to better understand the extent of this issue in BLMK and the reasons behind it. Furthermore, that the ICB develop a programme of engagement with men in general regarding their personal health and co-produce with residents communications activity focused on specific support available for male health.

Insight area	Recommendation
Cultural competency	Develop an Asset Based Community Development (ABCD) approach to engaging with local communities to drive grassroots change and represent their views in service development. ABCD is a way of local people taking the lead, and developing solutions for themselves, supported by statutory organisations, such as local councils. This would be achieved by ring-fenced investment being provided to VCSE and Healthwatch organisations to continue to build on the dialogue and trusted relationships developed in this review and lead to continuous improvements. Funding these organisations would enable them to proactively co-produce solutions with residents.
	Co-produce solutions with people from different backgrounds, including people with learning disabilities, young people affected by mental ill health and autism, and refugees, to adjust health services and the spaces in which they are delivered to make them more appropriate and inclusive.
	Co-produce services and training resources with transgender people, people from different ethnic minorities and cultures or faiths to increase awareness of individual needs, so that health and care professionals feel confident and empowered to better support patients. This will better support people when receiving diagnoses or delivering care for their specific needs.
	Develop an education programme for refugees to develop skills and independence to support them in understanding the health system and navigating it. This should also educate refugees on rights available to them, such as taking time off work to support family members and access to health and care.
	Undertake further research to understand the barriers that ethnic minorities including Gypsy, Roma, Travellers, face. Work with residents as part of an Asset Based Community Development approach to develop solutions for greater equality.
	Develop more service offers that involve going into communities, where people are most comfortable, such as pop-up centres, building on the successful approaches adopted through the COVID vaccination programme.
	Encourage health and care professionals to add a 'listening to patients' section to every training event to ensure lived experiences of local people are shared and professionals are given the opportunity to identify solutions to improve the quality of services / experiences.
	Review what is currently in place to provide healthcare advice, guidance and signposting information to residents. Develop a consistent approach so that people can get access to information about the services they need.

Embedding the recommendations through Quality Improvement

Our recommendations aim to tackle deep, longstanding issues, which are often complex.

To succeed, this requires a Quality Improvement (QI) approach, which involves staff and service users to explore the issues, unpick them, and develop services in a more person-centred way.

This means giving residents a much stronger voice, and thinking about what the ultimate goal is, rather than how organisations are currently run. Ultimately, residents need to feel that services have taken into account what they want, how they feel, and what is logical for them. It necessarily means being more flexible, and not rushing to judgement about what a person does or does not need.

By focusing on what residents and staff who work within services areas think, this should help to make inclusion something that is inherent within health and care services, part of their DNA.

Equality Delivery System (2022)

While much of the focus of our review has been on residents, we cannot forget staff members, who often live in the communities they serve.

The Equality Delivery System (EDS) helps NHS systems and organisations improve the services they provide while supporting better working environments, free of discrimination.

The main purpose of the EDS is to help the NHS, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010, such as sex, disability or race.

Therefore, part of the way we can reduce health inequalities is through ensuring the EDS is rigorously applied and appropriately scrutinised. There is an opportunity to apply the EDS when health and care providers procure new products and services, to create a more fair and equal health service for all, including NHS staff.

Accessible Information Standard

A big theme from residents was around accessibility. One of the ways better accessibility can be delivered is through the Accessible Information Standard. All organisations that provide NHS care or publicly-funded adult social care are legally required to follow the Standard. It sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Financial investment

This review has not put a price tag on its findings and recommendations. However, to deliver the generational change required to level the playing field, significant investment will be required to support the delivery of the above recommendations.

While it is recognised that considerable investment is needed across BLMK in its entirety, the Denny Review recommends that funding be prioritised in areas where there is a greater prevalence of known health inequalities.

Prioritisation of funding would support the Integrated Care System's prevention agenda. This is because data shows that areas with large populations of black and south Asian residents have greater numbers of people who contract diseases including type 2 diabetes, sickle cell anaemia, thalassaemia, long COVID, heart disease, cancer, as well as higher levels of infant and maternal mortality.

The quality of services is unequal in terms of availability and delivery. Therefore, spending needs to be prioritised to address historical inequalities so the past is not carried into the future. For example, more needs to be spent on preventing type 2 diabetes because this preventable disease significantly disproportionately affects Black and Asian people.

Conclusion

by Reverend Lloyd Denny

COVID-19 as a global emergency is now over. However, the long-term effects of the pandemic cast an uncertain shadow into the future. The inequalities identified in this report in terms of the disease and death and take-up of the COVID-19 vaccine were exacerbated due to a lack of trust in officialdom and in "the system".

To build trust, the challenge is to demystify decision-making processes, so they can be better understood. Furthermore, we need to make sure that there is cultural competency and diversity at senior levels of organisations. This is particularly important in the public sector.

Building trust will take time. Bedfordshire, Luton and Milton Keynes ICB, and all its system partners, need to acknowledge this and find ways to ensure that health inequalities for people from different communities or with different personal characteristics are mitigated against. Reducing health inequalities needs to become part of everyday business.

Leadership is the key to change. This review was commissioned to draw out recommendations and support system leaders to make evidence-based decisions. I have participated in NHS-wide events, discussions and meetings in connection with this review and have been assured that the review has national interest.

This report has focused on the experiences of the public as recipients of NHS services and care. The evidence shows there is clear disparity in the quality of care received and outcome.

I have seen for myself the benefits of good health and social care. The relief, joy and gratitude patients and their families have when a baby is successfully delivered at a hospital. The tears of joy when a life-saving medical procedure goes well. Sadly, good outcomes are not universal across the system. Sometimes this disparity is only a postcode away.

I hope that those in leadership positions in the health and social care system will recognise the scale of the change needed, rise to the challenge for the public wants it, and work with communities to bring about equality for all in the most basic of human need. A failure of leadership created some of the health inequalities faced by the Windrush generation. Therefore, we need to show, 75 years on, that we have learned.

These recommendations must be acted upon to help improve the healthcare system and to build residents' trust in it. If implementation of specific recommendations doesn't happen, the reasons why need to be clearly communicated.

Conclusion *continued*

Health inequality and inequity

There are many kinds of health inequality and several ways in which the term is used. Various definitions exist[11] but broadly speaking, health inequalities can be defined as:

- The avoidable and unfair differences in health across different groups of people
- Differences and biases in the access, quality and experiences of care
- The wider determinants of health, such as housing and income.

A further definition of health inequality by Lord Victor Adebowale, Chair, NHS Confederation: "Inequality is the way of the world; inequity is what we do with the way of the world."

Also from Lord Adebowale: "The NHS was not designed for inequality or inequity; it was designed to eradicate it. It should shame us that we are heading in the wrong direction. We have to make this core business. There isn't a plan B for the NHS."

We must heed these words, and those of residents and NHS staff, to make the changes we need, and demonstrate that serious action is being taken.

11 King's Fund (2020): What are health inequalities?

Agenda Item 7 – Delivering integrated Primary Care in BLMK

Appendix A – Place – Based Integrated Neighbourhood Working

Bedford Borough	At the Executive Delivery Group on the 15th November the proposed neighbourhood footprints were reviewed and supported subject to further work to define what should take place at neighbourhood, place and scale. The current 5 areas proposed are Urban South, Urban North East, Urban North West, Rural North and Rural South. As a first step in supporting stakeholder engagement a workshop took place on November 21st, facilitated by 'Skills For Care'. The focus was health and care colleagues working together.
Central Bedfordshire	The Central Bedfordshire (multi agency) Collaborative Group (a sub-group of the place board) is leading the development of integrated neighbourhood working. Footprints have been established centred on 4 familiar localities / neighbourhoods - Leighton Buzzard, Chiltern Hills, West Mid Beds and Ivel Valley. The existing work to develop a 'one team' approach in Central Bedfordshire (working together in Leighton Buzzard) provides a good platform for the development and expansion of neighbourhood working. A place-based workshop was held with all stakeholders on Friday 3 November with a second workshop planned 19 January; these workshops are facilitating delivery of the place priorities for Central Bedfordshire.
Luton	Neighbourhood profiles are well developed in Luton. There are 5 proposed footprints (West Luton, West Central, North Luton, East Luton and South and Town Centre). The work continues to develop at place and discussions are progressing about how place inequalities funding could be utilised to support neighbourhood working. A workshop took place on Tuesday 5 September with all Luton stakeholders to consider next steps to achieve the neighbourhood working vision and task and finish groups have now been established. Three pilot areas were agreed at the November HWBB.
Milton Keynes	Milton Keynes has established 'The Bletchley Pathfinder' as a fifth priority in the MK Deal with a multi-disciplinary / agency working group established to drive the work forward reporting to the Joint Leadership Team. The foundation work on the Bletchley Pathfinder project has good engagement from all parties. The Pathfinder project addresses all four of the Fuller Report Pillars although the majority of the access work is being delivered City-wide. Discussions regarding the proposed neighbourhoods for the rest of MK continue with Tayo Kufeji and the emerging Place Team working closely with system partners discussing a north/south/central/east/west, proposal.

Agenda Item 7 – Delivering integrated Primary Care in BLMK

Appendix B – Primary Care Commissioning and Assurance Committee Terms of Reference

Governance Handbook Appendix F Primary Care Commissioning and Assurance Committee Terms of Reference v2.0 approved by the Board of the Integrated Care Board 29-07-2022 with proposed amendments v3.0 approved by Primary Care Delivery Group and Primary Care Commissioning & Assurance Committee 15.09.23 subject to approval by the Board of the Integrated Care Board. Proposed amendments to the terms of reference for the Primary Care Commissioning and Assurance Committee will be presented to the Board for approval 23.09.2023 to incorporate the ICBs delegated responsibility from April 2023 primary care pharmacy, optometry and dental (includes acute and community) services from April 2023, subject to Board approval of delegation of these functions in March 2023. Changes to the Primary Care Delivery Group terms of reference will be made to incorporate primary care pharmacy, optometry and dental services.

1.0 Constitution

1.1 The Primary Care Commissioning and Assurance Committee (the Committee) is established by the Integrated Care Board (ICB) as a committee of the Board of the ICB (the Board) in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is a non-executive chaired committee of the Board, and its members are bound by the Standing Orders and other policies of the ICB.

2.0 Authority

2.1 The Primary Care Commissioning and Assurance Committee is accountable to the ICB and shall report to the Board on how it discharges its delegated primary care commissioning functions for primary medical services from July 2022 and primary community pharmacy, optometry and dental services from April 2023.

2.2 The ICB holds only those powers as delegated in these Terms of Reference as determined by the NHS England Commissioning Board.

3.0 Purpose

3.1 The Committee exists to scrutinise and provide assurance to the ICB that there is an effective system of primary care services including medical, pharmacy, optometry and dental services commissioning that supports it to

effectively deliver its statutory and strategic objectives and provide sustainable, high quality primary care.

3.1.1 The Committee acknowledges in exercising the ICB's functions (including those delegated to it), it must comply with the statutory duties as set out in the NHS Act 2006 (as amended by the Health and Care Act 2022), including:

a) Management of conflicts of interest (section 14O).
b) Duty to promote the NHS Constitution (section 14P).
c) Duty to exercise its functions effectively, efficiently and economically. (Section 14Q).
d) Duty as to improvement in quality of services (section 14R).
e) Duty in relation to quality of primary medical services (section 14S).
f) Duties as to reducing inequalities (section 14T).
g) Duty to promote the involvement of each patient (section 14U).
h) Duty as to patient choice (section 14V).
i) Duty as to promoting integration (section 14Z1).
j) Public involvement and consultation (section 14Z2).
k) Delivery of the ICB & Health & Care Partnership strategic objectives for primary care commissioning.

3.1.2 The Committee acknowledges that it is subject to any directions made by NHS England or the Secretary of State to the ICB.

3.2 Role of the Committee

3.2.1 The Committee has been established in accordance with the above statutory provisions to enable the members to, for example, make collective decisions on the review, planning and procurement of primary medical services, dental services and receive assurance reports pharmacy market entry requests through the regionally established ICBs Pharmaceutical Services Regulatory Committee (PSRC) which includes Bedfordshire, Luton and Milton Keynes under delegated authority from NHS England as set out in the national delegation agreement.

3.2.2 The role of the Committee shall be to carry out the functions relating to the commissioning of primary care services including primary medical, pharmacy, optometry and dental services under section 83 of the NHS Act 2006 (as amended by the Health and Care Act 2006).

3.2.3 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Bedfordshire, Luton and Milton Keynes ICB which will sit alongside the Scheme of Reservation and Delegation and these terms of reference.

3.2.4 The functions of the Committee are undertaken in the context of a desire to promote increased quality, efficiency, productivity and value for money and to remove administrative barriers.

3.2.5 NHS Bedfordshire, Luton and Milton Keynes to receive assurance from the regional Pharmaceutical Services Regulatory Committee (PSRC) in relation to community pharmacy services including market entry requests.

4.0 Membership and attendance

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint nine members of the Committee including two who are Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

4.3 When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

4.4 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

Chair and Deputy Chair

4.5 The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

4.6 If the Chair has a conflict of interest, then the co-chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

4.7 Members with Voting rights:

a) Non-Executive Member (Chair)
b) Non-Executive Member
c) ICB Chief Primary Care Officer
d) ICB Chief Finance Officer
e) ICB Chief Nursing Director
f) ICB Chief Medical Director
g) Three Clinical Representatives who have primary care leadership experience delivering either primary medical, primary dental and primary ophthalmic services or services that may be provided as pharmaceutical services, following appointment of the ICB Partner Members or clinical lead roles. One of these members will be the Deputy Chair of the Committee.

4.8 Other attendees – non voting.

4.8.1 The following non-voting attendees will be invited to attend the meetings of the Primary Care Commissioning and Assurance Committee, as subject area specialists and as pertinent to Agenda items:

a) Associate Director of Primary Care and Transformation
b) Associate Director of Primary Care Development
c) Associate Director of Transformation – Prevention Lead
d) Associate Director of Medicines Optimisation
e) One representative from each Health Watch (4)
f) One representative from each Local Medical Committee (2)
g) One representative from the Local Pharmaceutical Committees
h) One representative from the Local Optometry Committees
i) One representative from the Local Dentistry Committees
j) One representative from each Health and Wellbeing Boards
k) One or more Public Health Representatives.

5.0 Meeting Quoracy and Decisions

5.1 The Primary Care Commissioning and Assurance Committee shall meet in private and public on a quarterly (four times per year) basis (to be determined by the Board of the ICB). Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

5.1.1 Meetings of the Committee shall be held in public, subject to the application of a)

a) The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for the other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Quorum

5.2 There will be a minimum of one non-executive member - Chair for the meeting, ICB Chief Primary Care Officer or ICB Chief Medical Director, ICB Chief Finance Officer plus one other ICB Executive Board Member.

5.3 Where members are required for quoracy but unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate and vote on their behalf. No other deputies are permissible.

Decision making and voting.

5.4 Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.5 Only voting members of the Committee, or deputies for members required for quoracy, may vote. Each voting member is allowed one vote and a majority will be conclusive on any matter.

5.6 Where there is no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

6.0 Responsibilities of the Committee

6.1 The responsibilities of the Primary Care Commissioning and Assurance Committee are authorised by the Board of the ICB. The Committee will:

a) Review and approve recommendations made by the Primary Care (Medical Services) Delivery Group Primary Care (Pharmacy, Optometry and Dental)Delivery Group (Appendix 1) to include:

i. General Medical Services (GMS) and Alternative Provider of Medical Services (APMS) contracts (including the design of APMS contracts, performance of contracts, appropriate contractual action such as issuing branch/remedial notices and removing a contract) has been applied.

ii. General Dental Services (GDS) and Personal Dental Services (PDS), Specialist Community Dental Services (SCDS) and Acute Dental Service contract, performance of contracts, appropriate contractual action such as issuing branch/remedial notices and removing a contract) has been applied.

iii. Receive Pharmaceutical Services Regulatory Committee (PSRC) reports to provide the committee with assurance the PSRC is implementing the requirements of the community pharmacy regulatory framework.

iv. the commissioning of newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”).

v. Decision making on whether to establish new GP practices or dental practices in an area.

vi. Approving practice mergers.

vii. Approving primary medical services incorporation applications

viii. Making decisions relating to Primary Care Estates issues.

ix. Making decisions relating to Primary Care Digital issues.

x. Making decisions relating to Primary Care Workforce.

b) Utilise local clinical knowledge to influence the development of and investment in general practice to improve access to services and taking a population health management approach.

c) Develop and commission end to end care and increased autonomy to shape future primary care services including medical, pharmacy, optometry and dental services.

d) Take an active role in driving forward the NHS Long Term Plan.

e) Provide assurance on the budget for commissioning of primary medical services including pharmacy, optometry and dental services in Bedfordshire, Luton and Milton Keynes.
f) Plan, primary medical care, pharmacy, optometry and dental services in the BLMK area in response to population health assessments.
g) Undertake reviews of primary care services in the BLMK area, including primary medical services, community pharmacy, optometry and dental services.
h) Co-ordinate a common approach to the commissioning of primary care services generally.
i) Ensure collaborative working on monitoring and addressing issues of quality in primary care based on the principle of continuous improvement.
j) Recommend the key primary care priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.
k) Oversee and monitor delivery of primary care related ICB key statutory requirements.
l) Review and monitor those risks on the Board Assurance Framework and Corporate Risk Register which relate to primary care, and high-risk operational risks which could impact on care. Ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner.
m) Oversee and scrutinise the ICB's response to all relevant (as applicable to primary care) Directives, Regulations, national standards, policies, reports, reviews and best practice as issued by the Department of Health and Social Care, NHS England and other regulatory bodies / external agencies (e.g. Care Quality Commission, National Institute of Clinical Excellence), to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
n) Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the Board that these are disseminated and implemented across all sites.
o) Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place.
p) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people drawing on services.
q) Oversee the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.
r) Have oversight of and recommend approval of the terms of reference and approve work programmes for the groups reporting into the Primary Care Commissioning and Assurance Committee.

s) The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit.

t) Provide assurance on delivery of the Primary Care Strategy through the BLMK Fuller Neighbourhood Programme.

7.0 Behaviours and Conduct

ICB Values

7.1 Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and Diversity

7.2 Members must consider the equality and diversity implications of decisions they make.

Declarations of Interest

7.3 All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

8.0 Accountability and reporting

8.1 The Primary Care Commissioning and Assurance Committee is directly accountable to the Board. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board after each meeting and provide a report on assurances received, escalating any concerns where necessary.

8.2 The Committee will advise the Audit and Risk Assurance Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.

8.3 The Committee will receive scheduled assurance report from its delegated group the Executive led Primary Care Delivery Group which will include quarterly assurance reports from the Primary Care Workforce & Education Network Training Hub Steering Group, the Estates Working Group and the Primary Care Contracting Panel. Any delegated groups would need to be agreed by the ICB Board.

9.0 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed at least five working days before each meeting in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not attend at least 75% of meetings.
- Records of members' appointments and renewal dates are reviewed and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10.0 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These Terms of Reference will be reviewed at least every two years and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board for approval.

10.3 The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

11.0 Responsibilities of the Committee to provide assurance of Delegated Functions

11.1 The Primary Care Commissioning and Assurance Committee is responsible for providing the ICB with assurance in relation to its decisions for the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

i) Decisions made in relation to Directed and Local Enhanced Services and Local Incentive Schemes (including the design of such schemes).

ii) Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices.

iii) Decisions made about 'discretionary' payments.

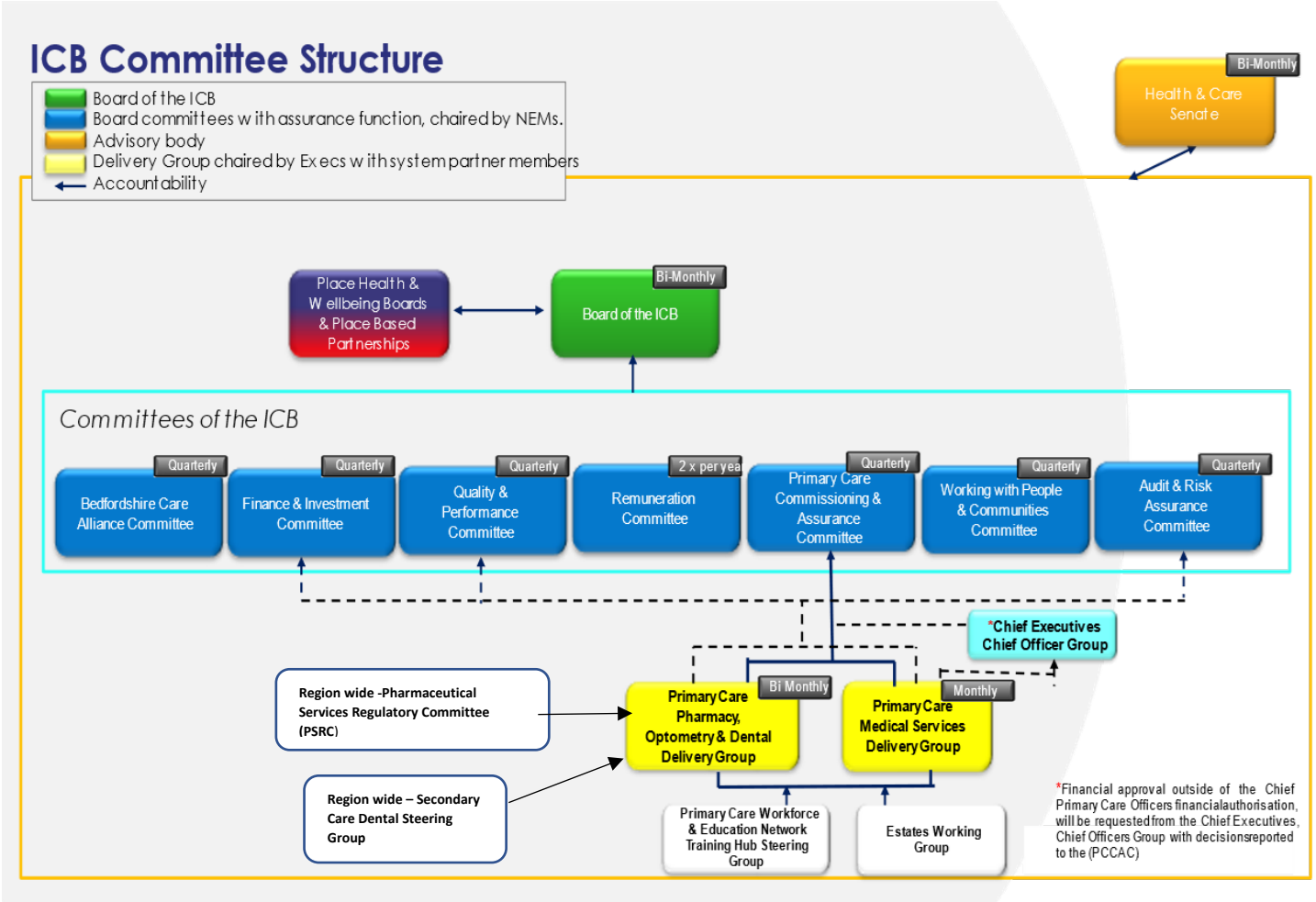
iv) Decisions about commissioning urgent same day access (including home visits as required) for out of area registered patients.

a) Ensuring robust planning for primary medical care services in the area, including carrying out needs assessments.
b) Undertaking reviews of primary medical care services in the area.
c) Providing assurance on contractual compliance and decision making in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list).
d) Providing assurance and oversight of the management of the delegated primary medical services funds in the area.
e) Ensuring compliance with the Premises Costs Directions (PCD) functions.
f) Co-ordination of a common approach to the commissioning of primary care services with other commissioners in the area where appropriate; and
g) Such other ancillary activities as are necessary to exercise the Delegated Functions.
h) Providing assurance on contractual compliance and decision making in relation to the management of poorly performing dental, pharmacy and optometry services including, without limitation, decisions and liaison with the Care Quality Commission where the Care Quality Commission has reported non-compliance with standards (but excluding any decisions in relation to the performers list).
i) Ensuring robust planning and integration of primary, community and acute dental care services in the area including the utilisation of the Public Health Dental Needs Assessment (DNA)
j) Ensuring robust planning and integration of community pharmacy services including the utilisation of the Public Health Pharmacy Needs Assessment (PNA)
k) Assurance of the integration of pharmacy, optometry and dental services including utilising public health prevention flexibilities within the contractual/framework.

Date of Approval – 29/09/202

For review 01/04/2024

Appendix 1 Committees Structure



The development of health and care integration in Milton Keynes

CONTROLLED DOCUMENT

Report of findings

October 2023

1. Introduction

In 2022, Milton Keynes (MK) was given city status, an important breakthrough for securing its local identity and endeavour to build a place for its communities and businesses to thrive. As now one of the UK's most productive and largest economies, the city has a diverse and fast-growing population of nearly 300,000 people. A largely coterminous set of health and care public sector organisations are working as part of the community in MK, they are Milton Keynes City Council (the Unitary Local Authority), Milton Keynes University Hospital (the acute provider), Central and North West London NHS Foundation Trust (the community health and mental health provider) and seven established PCNs.

Supported by its coterminous geography and clear identity, the health and care organisations in MK have long expressed strong ambitions to deliver transformative change for their population and respond to growing demand whilst containing system costs; it has been well recognised that collaboration is critical to meeting these goals. However, progress to realising these ambitions has been slow with the absence of formal arrangements through which to coordinate the work.

The joint work required to manage the Covid-19 pandemic provided an accelerant and the advent of Integrated Care Systems (ICSs), and a shift towards more collaborative, place-focused arrangements set out in legislation and NHSE's vision for *'Thriving Places',* created a renewed opportunity for cementing place-based working. In response to this, MK health and care partners have been embedding and maturing their model for place-based working and have achieved significant progress. This includes developing, agreeing, and working on a set of shared local priorities – the MK Deal – and aligning on these with the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB).

This report sets out findings and learnings from an independent review of progress in the MK place-based partnership, since it set out to determine its operating model in 2019. Carnall Farrar (CF) were commissioned to undertake the independent review having worked previously with health and care organisations in MK and in the wider BLMK ICS in 2019/20 to support the development of proposals for place-based arrangements and plans for joint working. In 2019 relationships were strained and extensive engagement was required to align partners on a collaborative agenda. This review has explored progress since this initial work. It has involved a desktop review collating findings from CF's previous work in BLMK and comparing this with documentation describing current MK place-based arrangements; observation of a MK Joint Leadership Team (JLT) meeting to observe governance and current ways of working; and 1:1 interviews with key partners from across MK Place and the BLMK ICB to explore progress, enablers and opportunities for the future.

The report outlines the journey MK health and care organisations have been on over the past four years, critical factors which have enabled their success, and opportunities for further development.

2. Where are MK now?

Context

Early in Government's plans to formalise ICSs and Place arrangements, health and care organisations in MK were already demonstrating significant appetite for change. Partners in MK recognised they were in a good position to accelerate place-based working; sharing ambitions to go further, faster, in working together to meet rising demand and system pressures. They were well-positioned with a clear MK identity, well-performing providers, stable finances, and the opportunity to scale the early stages of integrated care already underway.

Despite perceived readiness for change in MK, initial progress towards establishing a formal place-based model was slowed by the pandemic and other competing factors. Although agreed on an ambition for place-based working in MK, partners were unsure how to realise that future through new arrangements as the strategic commissioning policy emerged nationally alongside concepts of lead providers and devolved

commissioning responsibilities. Whilst the pandemic accelerated informal collaboration and relationships, its legacy of operational issues impacted progress, in part driving organisations to focus on individual agendas. In addition, relationships with, and between providers within, the historical commissioner landscape of MK CCG and combined BLMK CCGs were sometimes disjointed and challenging; there was a lack of transparency and bilateral relationships between each provider and commissioners used competition as a mechanism for change inhibiting collaboration.

Over recent years the context has begun shifting; greater progress has been made and ways of working within MK Place have evolved and matured to advance the MK place-based partnership agenda. Health and care partners have collectively developed and allied behind a shared vision and direction for the Place, supported by an effective governance structure, stronger collaboration, and maturing working relationships. The formation of the single BLMK CCG in 2021 supported an effective environment for change in the initial stages; new arrangements motivated MK health and care partners to rapidly secure an MK Place identity within the BLMK system, as well as encouraging the CCG to think more about delegation to Place and individual providers, and a transition to 'strategic commissioning'.

Governance and oversight

A clear governance structure led by the Council Chief Executive oversees, coordinates, and makes decisions for Place in MK. These structures are widely recognised across Place leaders and the wider system:

- **The Health and Care Partnership (HCP)** exists as an evolution of the MK Health and Wellbeing Board (H&WB). It is chaired by the Leader of MK City Council and draws on a range of partners from health, care and wider public services including Buckinghamshire Fire and Rescue, BLMK ICB, Central and North West London (CNWL) NHS Foundation Trust, Healthwatch, MK University Hospital NHS Foundation Trust, MK Council, Primary Care Networks, the Thames Valley Police and VCSEs. Whilst continuing to meet the statutory duties for H&WBs, the group functions as the place-based partnership for MK; it holds overall accountability for delivery of the place-based strategy and any responsibilities delegated by the BLMK ICB, including decisions for deploying resources allocated by the ICB to best meet local population needs.

- **The Joint Leadership Team (JLT)** is accountable to and reports to the HCP and acts more as a day-to-day management team to oversee and drive delivery of agreed place-based priorities and support effective collaboration between MK health and care partners. This team is chaired by the Chief Executive of MK City Council and meets every 3 weeks to progress action on key strategic areas. Membership includes two representatives from each of the MK provider Trusts, MK City Council, primary care and BLMK ICB.

Discussions supported by these structures led to the creation of the first-ever "MK Deal" – a clear, place-based strategy for MK focused on a select number of shared health and care priorities.

The MK Deal

The MK Deal was launched in December 2022 through a formal agreement and partnership between BLMK ICB and MK HCP. It marked a clear commitment to closer working across health and care partners in MK, established a clear remit and resourcing for the running and improvement of the local health and care system, and has driven forward change through the development of local priorities.

The MK Deal started out with four clear priorities, each with their own programme lead, steering group, success measures and progress reporting**.** The JLT and ICB agreed to work together to deliver these, combining resource and sharing workstreams, with the BLMK ICB playing an enabling and supporting role. These priorities are described in *Figure 1*.

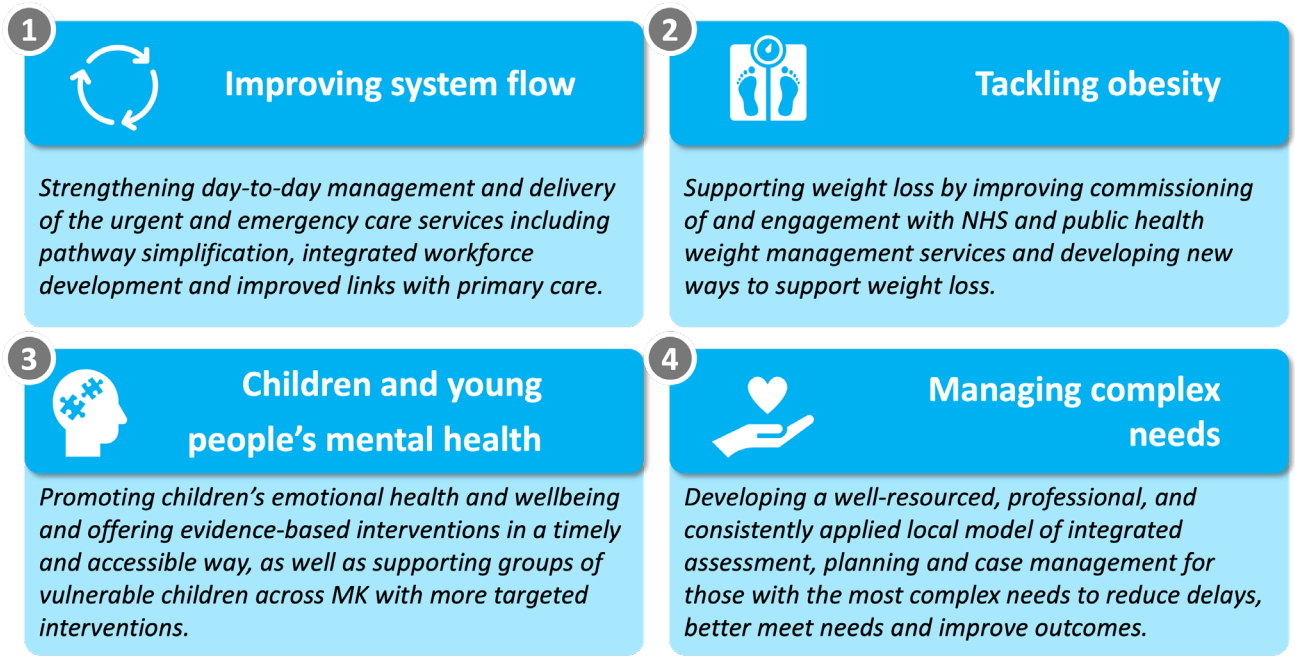


Figure 1: Four priority workstreams as part of the MK Deal, December 2022

Based on the Fuller stocktake findings, MK health and care partners are in the process of establishing a fifth priority on integrated locality (neighbourhood) working, with an initial focus on one neighbourhood referred to as the **'Bletchley Pathfinder'.** This would take a population health management approach, using insights from local population data and bringing together local partners and residents to deliver more proactive, personalised care at a neighbourhood level.

Progress across the MK Deal priorities to date has been variable, with some being further developed than others. This is in part driven by decisions to focus place-based transformation funding in particular areas and partly driven by variability of sufficient programme team resource to drive forward progress. Examples of the ongoing work within two of the most mature of the MK Deal priorities; Improving System Flow and Tackling Obesity; are provided in
Figure 2 and *Figure 3*.

Improving system flow - *Virtual wards initiative*

As part of the 'Improving system flow' priority, and in line with NHSE requirements to establish and expand virtual wards in 2022, MK health and care partners have designed a Virtual Ward composed of hub and spokes to look after patients in their own homes. An initial model for virtual wards has been developed and progressed into an agreed business case to secure significant financial investment.

A small task and finish group is responsible for leading on this work, reporting into the ICS steering group. Membership consists of subject matter experts from MKUH, CNWL and MK City Council, as well as wider advisory group membership from primary care, BLMK ICB and VCSEs. The group committed to both the development of the initial business case, and subsequent delivery of the agreed virtual wards model, ensuring continuity and commitment to delivery in line with the business case.

The business case proposes a hub and spoke model for virtual wards in MK:

- ***The virtual ward hubs** are intended to focus on more dependent patients with multiple comorbidities who often have clinical markers of frailty, and patients requiring the frequent input of specialist hospital consultants (e.g., cardiology or respiratory).*
- ***The virtual ward spokes** are intended to focus on patients with more specific healthcare needs, ordinarily relating to a single specific condition which can be managed by community care clinicians. These patients are less likely to have multiple clinical markers of frailty. Any medical input will be provided in conjunction with the patient's GP, or, where necessary through escalation to a virtual ward hub.*

Plans for virtual wards in MK Place will focus on a performance monitoring system that encourages the 'pulling' of patients into the virtual ward. The service aims to operate at close to capacity to help both mitigate and tolerate clinical risk, freeing up more physical hospital facilities. Outcomes of the scheme will be monitored by recording the extent to which patient needs are being met; the resources that are being deployed; and the acute hospital services that have been released.

Figure 2: Virtual wards initiative case study

Tackling Obesity - *Digital wearables project for diabetes patients*

As part of efforts to tackle obesity in MK, health and care partners are finalising plans to launch a digital incentive scheme across their diabetic population, with the intention of raising physical activity levels and assessing the impact of this on associated patient health outcomes.

The 'Tackling obesity' programme team in MK are due to launch a trial providing diabetic patients with:

1. *A digital wearable device to record physical activity;*
2. *Access to a phone application with personalised activity prescriptions, data and links to rewards;*
3. *Vouchers as rewards for achieving their physical activity goals.*

Health and care partners from MKUH, MK City Council, Primary Care, Loughborough University, Thames Valley Clinical Research Network and the BLMK ICB have been working in collaboration across sectors to deliver on this work, supported by a coterminous footprint with familiar stakeholders. Involvement of a research and development team from MKUH has provided clinicians the reassurance and confidence to engage, provided improved credibility to the work and strengthened the position to obtain the necessary data.

The trial will launch in September 2023 and will span 24 months with plans to recruit around 1000 participants via diabetic annual reviews. Half of patients will have immediate access to the interventions with the other half receiving interventions at 12 months. Patients will undergo regular follow-ups at their annual diabetes checks to collect data on clinical and patient outcomes such as HbA1c and quality of life. This is a unique and exciting opportunity for the population of MK and the trial will enable place-based teams to understand the cost effectiveness of the intervention for potential wider rollout.

Figure 3: Digital wearables project case study

How does this meet policy ambitions for place-based integration?

The place-based partnership approach adopted in MK embodies the aims set out in NHSE's *'Thriving Places'* guidance to make more effective use of combined local resources to drive local outcomes. *Figure 4* outlines how MK and ICB partners perceive its place-based arrangements to deliver against the responsibilities set out in this guidance. As place-based partnerships have no statutory functions, it is up to each individual Place to determine their specific responsibilities based on local requirements and priorities. The MK place-based partnership has intentionally focused its initial agenda on place-based strategy and service transformation rather than through delegation of statutory functions from the ICB with a more operational focus. Whilst there are intentions to widen the scope of the partnership in future, for example, through the adoption of more formal commissioning responsibilities, this table provides an assessment of current arrangements.

Key Significant existing maturity | Some evidence of maturity | Limited maturity

Proposed responsibilities for place-based partnerships, as set out in NHSE's 'Thriving Places' guidance	Maturity assessment of the MK place-based partnership (*with notes)*
Health and care strategy and planning at Place *Supporting development and delivery of strategy at place, in line with both local and system-wide priorities*	*Developed the 'MK Deal' outlining the strategy for Place with a set of focused priorities and corresponding programme steering groups to coordinate delivery of work*
Service delivery and transformation *Integrate and coordinate the delivery of health, social care and public health services around the needs of local population, and empower people who use the services*	*Current focus has been more on service transformation with evidence of collaboration on integrated service delivery e.g. empowering service users through digital wearables project.*
Connect support in the community *Work with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing*	*Efforts to engage wider community partners are shown through existing priority work e.g. digital wearables project, which utilises annual diabetes health checks to identify and monitor patients. The Bletchley Pathfinder priority is likely to drive further community connections.*
Align management support *Collectively agree options to align and share resources*	*The HCP brings together health and care partners from across MK to collectively decide how to deploy resources allocated by the ICB to Place to best meet the needs of the MK population.*
Promote health and wellbeing *Work with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability*	*There is a variety of work underway in MK to promote and improve wider population health and wellbeing. For example, the Tacking Obesity priority is conducting work to identify and implement actions to address the spectrum of health and wellbeing drivers related to obesity, including the wider determinants of health across MK such as advertising. Furthermore, the MK50 plan outlines ambitions for MK Place by 2050, with strong emphasis as a healthy city and working to reduce inequalities. Work through the Bletchley Pathfinder priority will support this goal by engaging wider system partners and looking to further explore and address the wider determinants of health.*
Service planning *Taking responsibility for elements of the commissioning cycle*	*The ICB has agreed to be led by the MK place-based partnership on the commissioning of services in scope of MK Deal priorities and there is a potential opportunity to mature this function in future (for example, delegation of formal commissioning responsibilities from the ICB to Place)*
Population health management *Drawing on population health insight to support care redesign locally and address health inequalities*	*The Tackling Obesity priority has demonstrated a data-driven approach to tackling obesity across the spectrum of population health, from the healthcare focused end of increasing access to and uptake of weight management services, through to embedding innovation (e.g. wearables) for upstream obesity management and prevention solutions, and shaping the wider environment and determinants of health across MK.* *Whilst this data-driven population health approach provides an effective building block for driving forward more targeted population health management (PHM), further work is required to adopt a PHM approach. This includes continuous use of data to segment and risk stratify local populations, development of targeted interventions to improve outcomes*

	for those segments address health inequalities and implementing a neighbourhood-based multi-disciplinary team delivery model. The emergent Bletchley Pathfinder priority is expected to drive a greater focus on PHM and meet current gaps in this approach.

Figure 4: Maturity assessment of MK place-based partnership arrangements against NHSE "Thriving Places" guidance

The Integration White Paper published in February 2022 has a significant focus on improving integration of health and care across all sectors within Place, as well as allowing significant opportunity for increased local decision-making. The paper highlights the importance of adopting a robust governance model, a dedicated leader who is accountable for delivery of the place-based strategy and leveraging the use of pooled budgets between NHS and local government, all of which are being demonstrated in MK. The paper also describes the intention for Places to develop additional local priorities based on national NHS objectives; the MK place-based partnership has reflected these in the MK Deal priorities where relevant and recognise their responsibility to support their delivery. BLMK ICB are looking to establish more robust mechanisms to report progress against these priorities to place-based forums and across the ICS.

Whilst progress against the national priorities continues to be monitored by the ICB, reporting of these national priorities into the HCP/JLT will need to be established with the hope to address this through the implementation of place-based teams from the ICB.

3. What have been the critical success factors?

A series of success factors have been critical to building the collaboration, including the shared vision for health and care and the effective governance in the MK place-based partnership. **The five enabling factors outlined below** have been fundamental to secure direction, alignment, and commitment across MK's health and care leadership - all essential components for high-performing leadership teams.[1]

1. Alignment around a shared direction and focused priorities

The clear, coterminous geographical and health and care provider footprint has supported MK to establish a clear identity as a 'Place'; with established organisational partnerships and delivery structures providing a significant foundation to build upon.

The MK Deal has clearly set the direction and focus for health and care partners in MK and has built a strong sense of shared ownership of, and commitment to, the MK Deal priorities. In part, this was enabled by the place-based partnership having the space and autonomy to develop this independently and bottom-up around local needs and shared strategic objectives. The process involved in developing the MK Deal, as much as the deal itself, has been critical to building collaborative approaches across health and care partners through shared problem-solving. It has helped to build stronger relationships and trust between leaders, breaking down historical barriers and shifting focus from internal facing to aligning around the new shared direction.

Being intentionally selective and limiting numbers of priorities has ensured discussions are more delivery focused and workloads are more manageable, supporting more effective delivery and greater impact. The shared and focused direction in the form of the MK Deal has allowed the JLT to dedicate energy and time to making tangible progress on a select number of priority areas.

The MK Deal priorities are clear, visible, and accessible meaning wider partners and the public outside of the formal governance understand what the priorities stand for and share a commitment to the same direction. This widespread awareness is supported by the engagement of local politicians and Healthwatch MK in the development of the priorities, creating local energy and momentum around driving change.

[1] DAC model, Center for Creative Leadership

"There is a real sense of shared ownership than previously. The priority work has helped to build local relationships and trust by solving problems together."

"We have benefitted from not trying to do everything and focusing on a small number of priority areas."

"I have been really impressed with the contributions from politicians and Healthwatch in MK – they have been strategic and supportive of the whole approach in MK, ensuring questions are constructive. Healthwatch representatives have shown understanding and shared ownership of the MK Deal work."

2. Resource dedicated to place-based priorities

Transformation funding provided by the ICB, and in turn ringfenced by the HCP for MK Deal priorities, has been critical to progress collaborative working on shared priorities. Having dedicated budget for these from the outset has enabled a focus on delivery and action through place-based discussions, by providing partners with the resource and authority to implement joint decisions.

Resource in the form of workforce has also been key to progressing place-led work. BLMK ICB has committed to providing a dedicated team for the MK Deal in the form of the MK Improvement Action Team. In addition, having ICB place-based representatives on the HCP and JLT has been vital to broker conversations and build understanding and relationships between place-based leaders and the ICB. Participation from the ICB has provided line of sight in both directions and facilitated greater transparency in communications by clearly translating the intentions of each, whilst effectively balancing the level of input required from the ICB with clear efforts to maintain the autonomy of Place.

Having people internally in MK Place who are aligned and focused on driving forward the MK Deal priorities has helped coordinate efforts to meet key milestones and timely programme delivery. Health and care organisations have shown commitment to the shared vision by dedicating a consistent set of senior representatives to form core governance structures and attend meetings in person. A key part of this is through the JLT which convenes senior representation from across Place on a regular basis to coordinate delivery of place-based priorities. JLT members also commit significant time and energy outside of JLT meetings to act as programme leads for the MK Deal priorities, as well as dedicating members of their own organisation's staff to act as part of the integrated programme steering groups. This shows shared ownership and support for the place-led agenda across organisational boundaries.

"MK has been provided money and the authority to work together in this space."

"ICB representatives within MK governance structures have acted as an effective translation service for the ICB, whilst ensuring the autonomy of Place is maintained to pursue their own agenda."

"Staff have been allowed dedicated time to work on the MK Deal priorities by their host organisations."

3. Strong leadership from the Council

The leadership shown by the Council for the MK Deal, HCP and JLT has been widely identified as critical. Both in acting as an honest broker in NHS-focused discussions and as an equal partner in discussions with the NHS. The involvement of the Council in this way has facilitated meaningful engagement across different sectors grounded in place-based needs, and helped build integration, relationships, and collaborative working into the governance of the MK place-based partnership. The Council's significant involvement has also created a firmer understanding of the roles of the NHS and the Council, that were historically blurred, developing a common language between the two.

In particular, the Chief Executive of MK City Council, a well-respected figure in MK, has been instrumental in supporting and brokering the MK Deal and providing strong leadership of its place-based governance structures. Often taking ownership for local health and care decisions in a unique and progressive way for a place-based system, many have reflected on the significant cultural change this has created across health and care partners in MK.

"Leadership from the council has been pretty fantastic - helping bring leaders across place together and manage engagement with wider partners effectively."

"The bravery of a couple of key individuals in the JLT has been particularly important and the JLT team has supported them to do this… leadership from the Council CEO in particular has been very significant."

4. Clear leadership, decision-making and governance arrangements

Place-based arrangements in MK are underpinned by an effective governance structure composed of two principal groups: the HCP and JLT. Together, these provide complementary forums for discussions to occur between place-based partners that enable effective decision-making, oversight, and delivery of health and care for the whole of MK. There is widespread clarity on the purpose, roles and responsibilities of the HCP and JLT; and each has its own Terms of Reference, membership and clear alignment of the role and decision-making authorities of each in relation to one another. The HCP meets every three months as the strategic overarching structure for place, taking overall responsibility for decisions on how to spend the transformation budget. The JLT meets every three weeks, functioning as the day-to-day leadership team progressing and operationalising the MK Deal and reporting into the HCP.

The JLT is considered a core feature of the MK place-based partnership's success, acting as a productive and action-focused forum to coordinate and oversee delivery of the place-based agenda, convening the Council, ICB and all NHS providers on a regular basis. Key features of the JLT include:

- **A focused and targeted membership** composed of core place-based health and care partners considered to have the greatest knowledge of MK Place and role in delivering its health and care priorities;
- **A balanced membership structure** which ensures all partners have an equal voice at the table by comprising two representatives from each of the NHS Trusts, the MK Council, primary care and ICB;
- **Consistency in membership** and thus meeting attendees has created continuity and familiarity with decision-making processes, as well as enabling senior leads to build relationships through regular interaction;
- **Seniority in membership** and dedication of senior people to attending these meetings means that those who are at the meeting and contributing can drive action;
- **Short and focused meeting agendas**, with only the most relevant information provided and discussed. This means time is spent on brainstorming and tackling difficult issues to generate clear actions and agenda items have a focus on MK Deal priorities which all partners in Place have bought into;
- **Face-to-face meetings**, essential for building lasting and trusted relationships;
- **A safe space** for healthy debate between partners where voices are respected, differences in opinion are discussed openly and shared actions can be agreed and taken forward.

In addition to these fora, each deal priority has its own integrated steering group with dedicated leads and representation from relevant health and care partners across MK. Some of whom sit on the JLT and with dedicated resource from across Place and providers. These steering groups have delegated responsibilities and decision-making powers to drive forward work on the MK Deal priorities.

The governance described has supported strong, collaborative, and more equitable relationships across provider organisations and commissioners. As a result, place-based working in MK has shifted from dispersed teams aligned to individual organisations to a joint management team meeting regularly and partnering on shared agendas. As a result, individuals across NHS and local government have a greater understanding for each other's roles and priorities.

"Face-to-face meetings of the JLT have been massively effective to build relationships and familiarity."

"JLT meetings involve senior people attending in person every 3 weeks for 1.2-2 hours – this commitment and focus from organisations and senior people is very powerful"

5. Cross-organisational and sector collaboration founded on closer partnerships

There is a positive culture founded on familiarity and relationships, alignment on shared priorities and willingness to collaborate and an equal and safe platform for the voices of different providers and leaders. This significant cultural shift in how partners communicate and perceive their relationships with one another has been critical to the transformation of MK's place-based arrangements. Where leaders were previously focused on specific organisational needs (leading to tensions and limited progress), now they communicate with one another as equals and leader-to-leader, understanding different perspectives and having more open discussions about the shared agenda. There is a mutual respect of one another and a continuity of relationships, as well as a recognition that partnership working is essential to achieve individual as well as collective success. Differences in opinions which naturally exist are managed respectfully between individuals through open, inclusive, and constructive debates to reach a shared agreement. Outside of governance structures, partners have clear lines of communication in place to regularly make themselves available to one another, with operational bilateral discussions often taking place.

> *"The JLT act as critical friends to one another and we always bring each other back around to the key priorities."*
>
> *"There is very positive attitude, culture and way of working together which is straight-talking and adult-adult, but also focused on getting stuff done and sorting stuff out in a pacey, no-nonsense manner."*

4. Opportunities for further progress

The place-based partnership in MK has built strong foundations through its place-based vision, priorities and partnership structures for health and care. This provides a progressive and exciting platform to go even further in setting out and delivering its intentions and priorities for Place.

Driving a population health management approach

Population health management (PHM) is critical to improving local population outcomes and reducing health inequalities. Effective PHM requires use of local data to segment and risk stratify local populations, development of targeted interventions to improve outcomes and address health inequalities, and establishment of a neighbourhood-based multi-disciplinary delivery model. As a key component of the ambitions set out in *'Thriving Places'*, the vision has always been for PHM to form a core responsibility of the MK place-based partnership.

MK's Tackling Obesity priority demonstrates an approach to improving population health through three strands of work: 1. Using insights from data to identify and improve patient access to weight management services; 2. Innovation, such as digital wearables; and 3. Shaping the wider environment and determinants of health. Whilst this work provides a strong foundation for effective PHM in MK, further work is required to adopt the PHM approach as described in *'Thriving Places'* and above.

The new Bletchley Pathfinder priority has the potential to significantly accelerate and bridge the gaps for population health management in MK by enhancing maturity and setting the direction for other neighbourhoods. It also provides an opportunity to better engage MK residents and the wider network of health and care providers such as primary care partners and VCSEs; all essential partners for delivering effective population health management. In line with the ambitions of the Fuller Stocktake to establish multi-disciplinary neighbourhood teams at a place-level, the MK place-based partnership will need to consider how best to engage and involve these voices in place-led decisions, and whether this requires new governance arrangements to do so. This will be supported by the provision of additional primary care roles and integrated neighbourhood manager roles dedicated to Place as part of the ICB's new resourcing structure.

"The place-based partnership in MK is not currently looking at population health in its entirety. As they mature, they should review local data to identify priorities that can make a real difference to local population outcomes. Bletchley pathfinder will be a good opportunity for this."

"There is a need to bring more voices from primary care, VCSEs and local residents around the table at place-level – at the moment representation is only from general practice."

Agreement of future funding to support Place priorities

The availability of a shared transformation fund for the MK HCP has been critical to securing collaboration and alignment across teams and enabling tangible progress on the shared priorities to date. However, there is no expectation for this funding to continue into future years. Absence of dedicated funding for MK to sustain existing initiatives and initiate further work risks collaboration becoming less action-focused and more reflection-based, compromising existing developments and limiting further evolution of the place-based partnership. To enable MK health and care partners to continue working collaboratively, and with autonomy to drive forward transformation at Place, the ICB and the MK HCP will need to co-develop a shared plan for funding ongoing transformation work; this should look to identify a recurrent budget, from existing ICB and Place resources, to allocate to place-led activities. Current financial pressures in the system underline the importance of mutual commitment to this work from all health and care partners, as well as establishing clear reporting and assurance structures to demonstrate impact of investment.

To date, discussions between health and care partners in MK have predominantly focused on how best to spend money on transformation initiatives, rather than considering shared ways to generate financial savings in MK Place. Whilst continued funding to support further transformation work is important, the MK place-based partnership, enabled by the ICB, should also consider ways to collaborate to save money for the system, as well as how best to contribute to ICB decision-making on the most effective use of core funds.

"We need a medium-term financial plan for MK Place as money will ultimately become the blocker to further progress once it runs out"

"So far, we have focused on spending interesting discretionary transformation funding. We have not yet been collaborating to save money or involve ourselves in the decision-making processes for core funds."

Aligning on the target operating model for Place-led functions

To date, MK HCP has intentionally focused on delivering transformation work rather than the operational responsibilities of the ICB. This is reflected in its responsibilities in the ICB's latest target operating model. However, future aspirations are for the MK partnership to transition to leading commissioning of some services associated with the MK Deal priorities. This involves defining how far it wants to take a greater role in commissioning; whether this continues to have a transformation-only focus or if responsibilities spread wider into leading other elements of commissioning, such as performance monitoring and assurance. The ICB needs to support MK HCP to align on the right balance and any associated resource requirements.

The level of resource required to support these future arrangements in Place needs to be affordable to the BLMK system, originate from both MK-based organisations and the ICB, and be proportionate to the level of responsibility taken on by the MK HCP. It is also important that the resource dedicated to the MK place-based partnership – distinct from resource provided by individual partners – can facilitate the necessary assurance required from each statutory organisation in terms of performance against the priority areas. For example, the leadership of commissioning functions means facilitating the assurance required of the ICB and the Council. With significant presence on the ICB from MK there is already a governance alignment that can be leveraged. Additional specific responsibilities and the associated resources will need to be clearly defined through open dialogue between the ICB and the MK HCP and agreed by all partners.

"The ICB restructure will better define resource for places in terms of having a funded core team able to support the MK deal priority programmes"

"If we were provided additional people to work within Place we would progress faster"

Building resilience and flexibility within Place

The leadership and relationships of the JLT and HCP lie at the core of their place-based success and positive culture. This is specifically rooted in the strong personalities and reputations of those leading the place-based agenda. Whilst extremely positive, it also highlights the need to sufficiently embed and codify the positive, collaborative culture that has been created by these individuals across all levels of Place to ensure the partnership can endure future changes in leadership and to support dissemination down to all levels of each organisation. An effective change management programme, supported by the ICB, could help to inform individuals below leadership levels of the changes occurring within MK place and how this impacts their ability to inform and impact health and care service transformation.

In addition to establishing a resilience in culture, the MK Deal priorities and associated governance will need to adapt to expand their scope, alter their direction, and strive for greater ambition as the MK place-based partnership matures, reflecting on and learning from previous priorities. A structured and regular review process will be essential to support flexibility and evolution of the priorities whilst ensuring the continued effectiveness and oversight of place-based arrangements. Selecting the right moment to commence this review cycle will be key to secure ongoing success.

> *"Would like to extend the scope of the deal into other areas at some point but choosing the right moment to do this will be important."*
>
> *"If there is any risk in the model at the moment it's because it hinges on specific personalities so need to make sure the culture is embedded."*

5. Conclusion

Health and care partners in MK have dedicated significant effort over the past few years to building an effective and pioneering approach to MK's place-based model of working, supported by BLMK ICB. There are clear governance structures in place to formalise the partnership and enable tangible progress, and relationships have evolved significantly with partners now working towards the same direction. Additionally, the place-based partnership in MK is already demonstrating an approach aligned to many elements set out in the NHSE's guidance for "Thriving Places", with plans to mature further in other areas.

Development of the MK Deal, the first of its kind in BLMK ICS, has been critical to transforming place-based relationships and aligning partners towards common goals, shifting the way in which organisations work together to transform health and care in MK. The progress made so far would not have been possible without dedicated resource to deliver on these agreed priorities, strong leadership from the council acting as honest-brokers to facilitate place-based discussions and a robust governance structure with forums such as the JLT dedicated to delivering this work. This is all underpinned by a cultural shift in the way in which partners are communicating and making themselves accessible to one another now they are agreed on a shared direction.

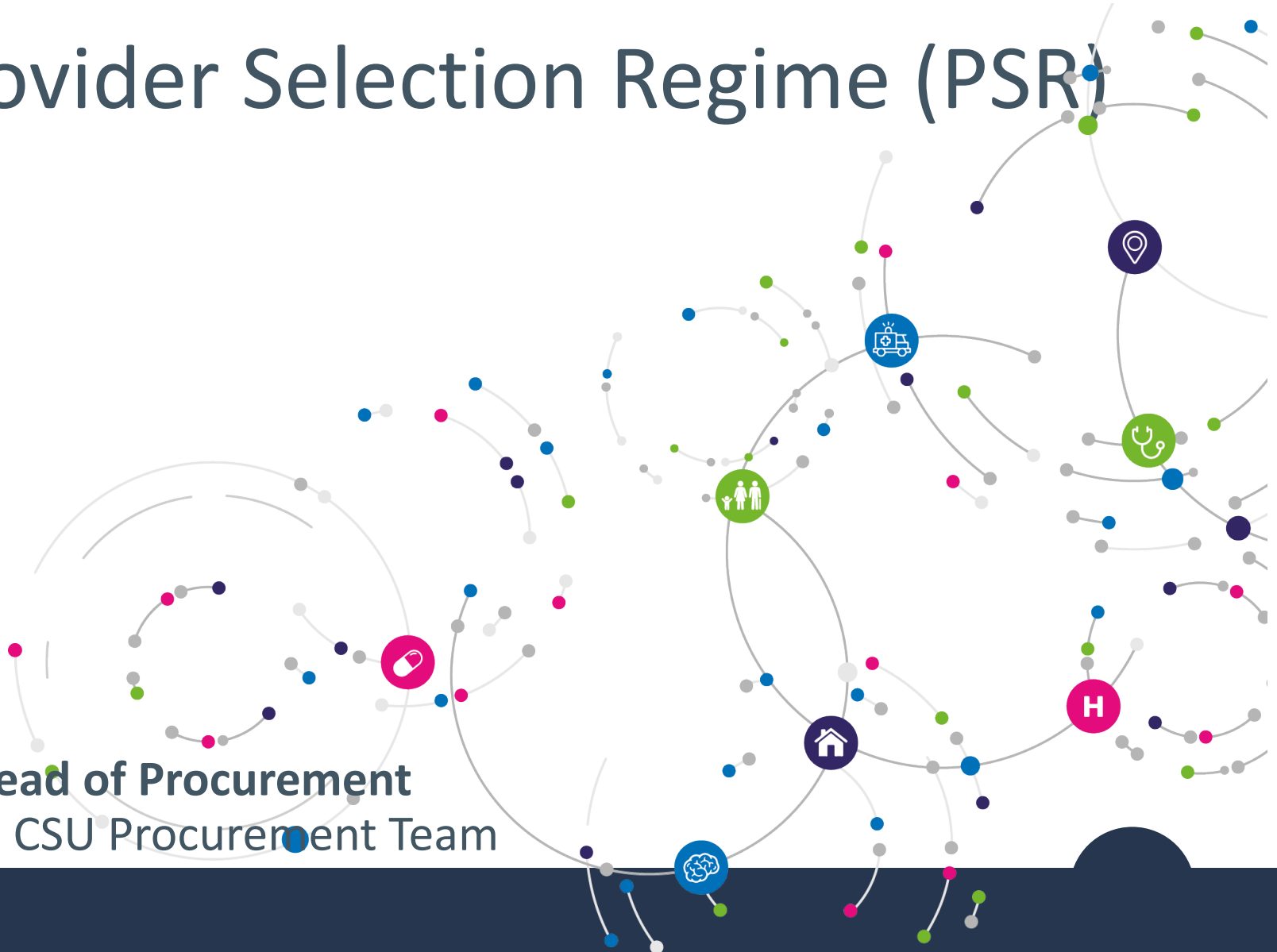
With these critical foundations in place, the MK place-based partnership should look for ways to develop further as they progress delivery of the MK Deal priorities. The partnership should view the Bletchley Pathfinder work as a leading opportunity to involve wider partners in place-based discussions and deliver more ambitious transformation at a neighbourhood level; using local insights to deliver population-specific initiatives and help reduce health inequalities for MK. To support continued delivery of MK Deal priorities, the partnership will need to work collaboratively with the ICB to identify continued funding, agree on a suitable place-based workforce to deliver the work, and communicate any commissioning responsibilities they will adopt as the place-based partnership matures. Core to strengthening place-based arrangements in MK, the Place and ICB should support a cross-organisational and sector change management programme to disseminate information and establish a results-driven culture, similar to the MK leadership team, across all levels of Place.

Although this review did not involve comprehensive benchmarking analysis of MK against other Places, the CEO of Carnall Farrar, Hannah Farrar, provided her views on how the MK place-based partnership is performing based on her extensive experience working with other Places across England:

"CF has worked with multiple Places at different stages of development across the country. There are examples of Places further developed than MK and these have informed some of the recommendations of this report. However, many Places are yet to have developed and implemented a model in the same way as MK, with the Council taking a leadership role on a clear set of local health and care priorities by convening Local Government and the NHS. MK has succeeded in building effective partnerships with a shared mission and demonstrable progress in delivering improvements for residents."

– Hannah Farrar, CEO of Carnall Farrar

NHS Provider Selection Regime (PSR)



Ros Clarke, Head of Procurement
Arden & GEM CSU Procurement Team

Provider Selection Regime (PSR) Regulations - Introduction

- PSR* regulations come into force on 01st January 2024 and will replace:
  - The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 (PPCCR 2013) and,
  - The Public Contracts Regulations 2015 (PCR 2015).

  this is subject to parliamentary scrutiny and agreement.
- PSR has been designed to support greater integration, wider collaboration across systems, offer a flexible and proportionate process for selecting providers of health care services
- Organisations referred to as 'Relevant Authorities' are required to follow PSR:
  - Integrated Care Boards (ICBs),
  - NHS England (NHSE),
  - NHS Trusts and Foundation Trusts,
  - Local Authorities,
  - Combined authorities.

*Please note that PSR applies to Clinical Healthcare Services Procurement (NHS and local authority funded health care services) only, unless it is a construed as a mixed procurement (clinical and goods /non-clinical services).

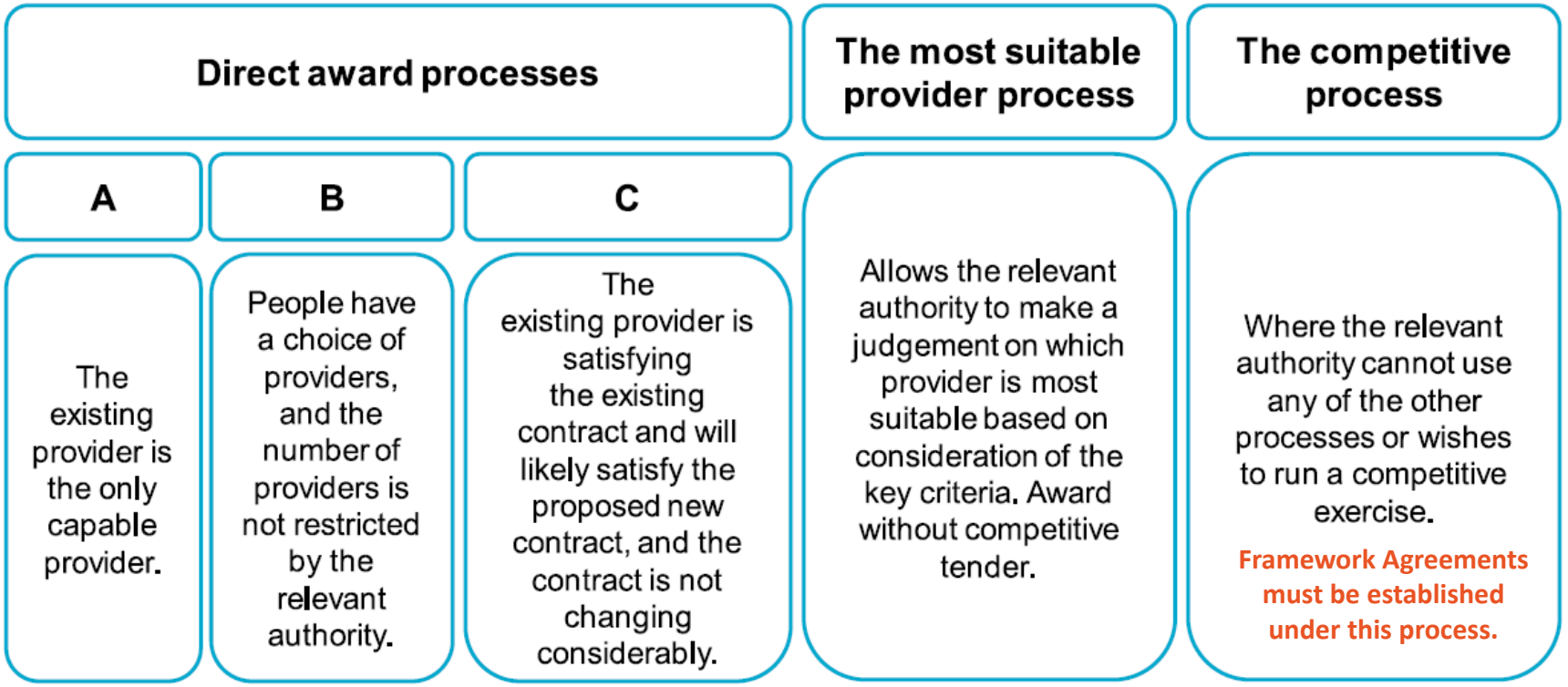
PSR Regulations – Overview and Planning

- PSR requires relevant authorities to consider value for money (VfM) as an important criterion, and in their decision-making to be
  - transparent,
  - fair, and
  - proportionate.

  this is in line with the existing principles of Procurement.
- Relevant authorities are expected to identify which provider selection process is applicable sufficiently in advance of a contract coming to an end.
- It is permitted to make certain modifications during the term of a contract to allow for changes to services or circumstances.
- In limited circumstances relevant authorities may need to act rapidly, for example, to address immediate risks to patient or public safety, within which it would be impractical to follow the steps required under this regime.

PSR Regulations – Selection Process(es):

- There are three provider selection processes that relevant authorities can follow to award contracts for health care services.



- Relevant authorities will need to comply with certain defined processes in each case to evidence their decision-making, including the publication of transparency notices, record keeping and the SFIs and governance processes of the relevant authority.

PSR Regulations – Key Criteria

- Five key criteria must be considered when making decisions about provider selection under:
  - direct award process C,
  - the most suitable provider process, and
  - the competitive process of this regime.

- When assessing a provider(s) against the key criteria, all five key criteria must be considered, and none should be discounted.

PSR Regulations – Transparency

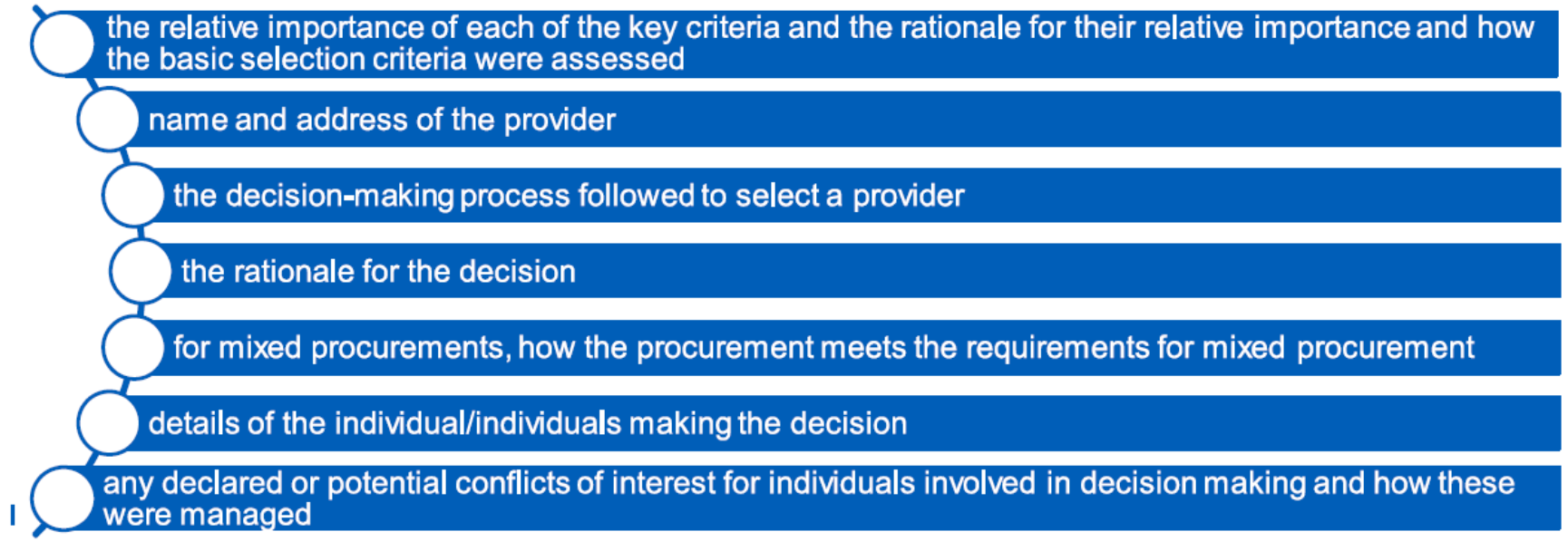
- Relevant authorities must follow the transparency process relevant to the approach being followed.

process	decision-making processes					framework agreements		
	direct award processes			the most suitable provider process	the competitive process	establishing a framework agreement	contracts based on a framework agreement without competition	contracts based on a framework agreement following competition
	A	B	C					
Making intentions clear in advance								
Publishing the intended approach in advance				✓				
Publishing a notice for a competitive tender					✓	✓		
Communication of the decision								
Publishing the intention to award notice			✓	✓	✓	✓		✓
Confirmation of the decision								
Publishing a confirmation of award notice	✓	✓	✓	✓	✓	✓	✓	✓
Contract modification								
Publishing a notice for contract modifications	✓	✓	✓	✓	✓	✓	✓	✓

- All decisions must have been made in line with the SFIs and governance processes of the relevant authority.

PSR Regulations – Keeping Records

- Relevant authorities must make and keep clear records detailing their decision-making process and rationale for all provider selection processes and must include:



- Relevant authorities must also make and keep clear records where a provider selection process was abandoned or where the relevant authority decided to return to an earlier step in the process.

PSR Regulations – Standstill Period (SSP)

- A Standstill Period (SSP) must be observed

When following direct award process C, the most suitable provider process, and the competitive process – following the publication of the Intention to Award a Contract – the **relevant authority must observe the standstill period.**

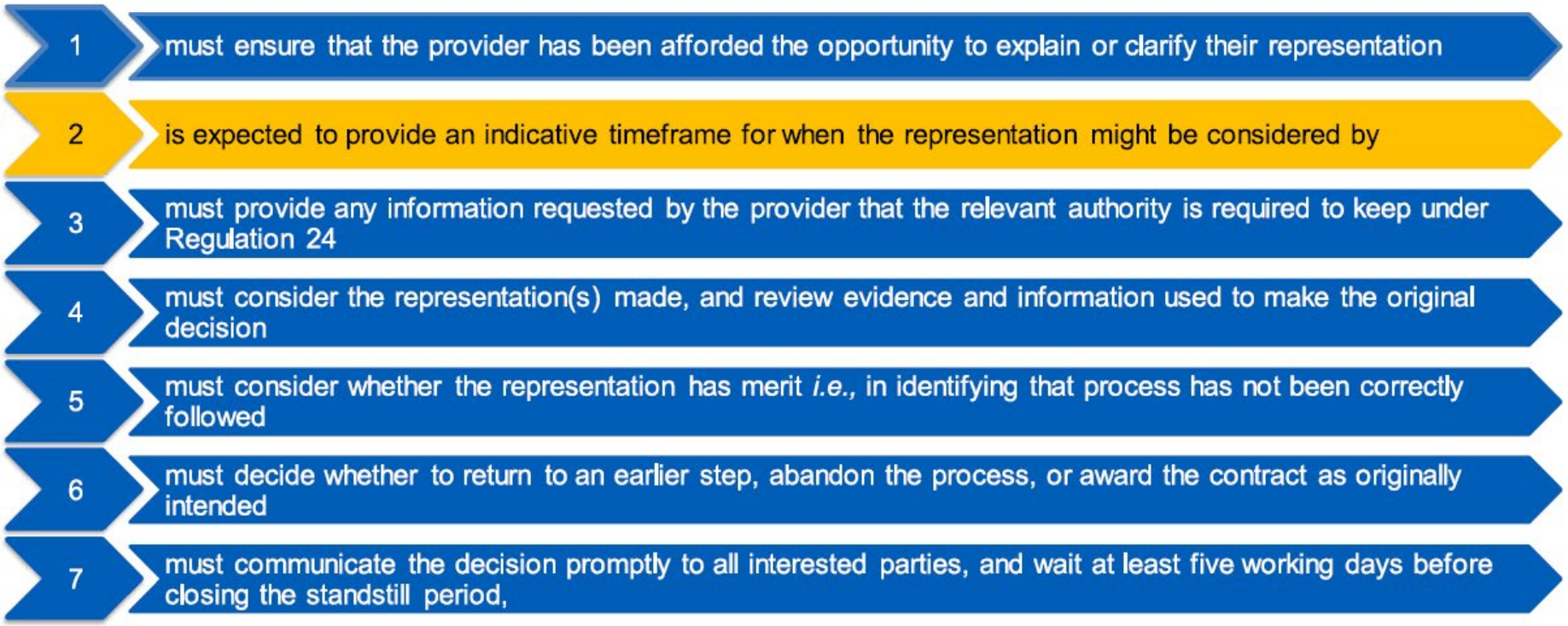
It is a period of **eight working days** (which may be extended) during which representations can be made and must be responded to.

The standstill period allows the relevant authority to consider any representations received and to respond as appropriate. The relevant authority must allow the provider **five working days** to consider their feedback before closing the standstill period.

The standstill period should be extended (unless in exceptional circumstances) if the representation is considered by the PSR Review Panel. **(NHS England)**

PSR Regulations – Representations

- If a representation is received, Relevant Authorities:

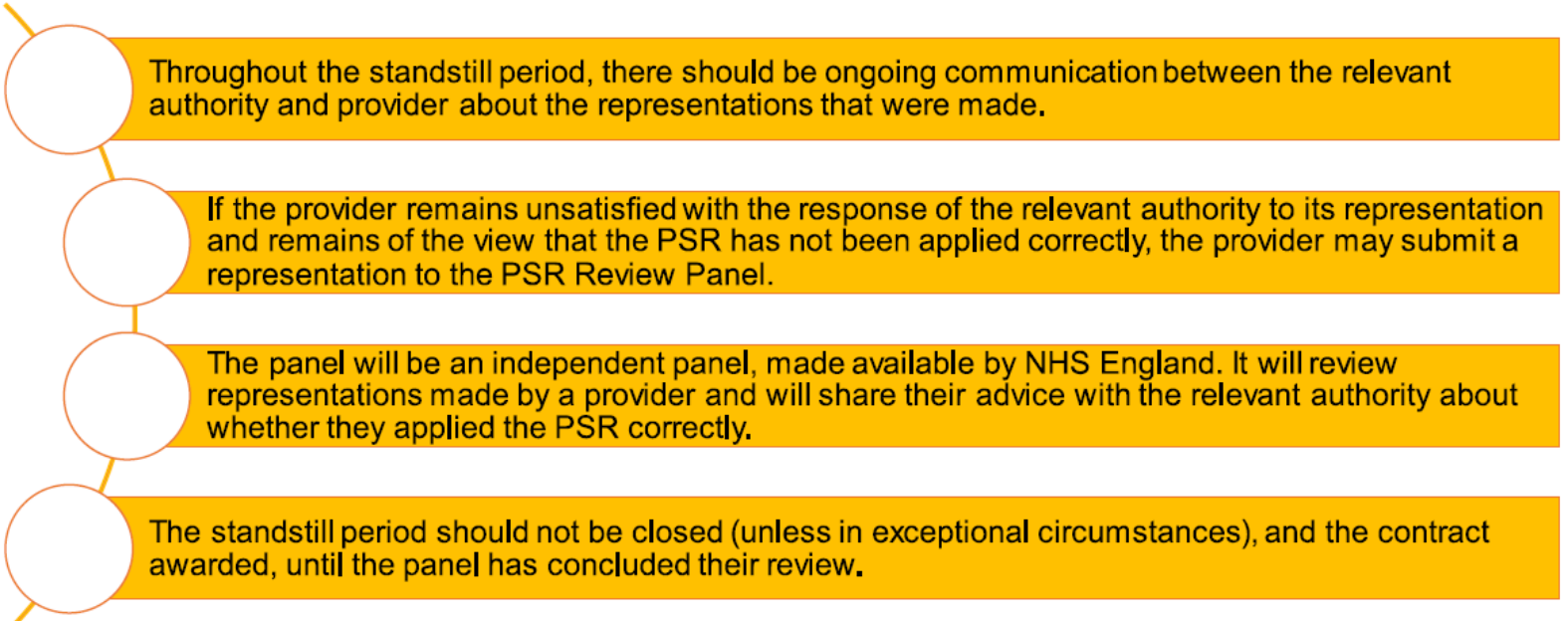


PSR Regulations – Representations (Consideration)

- Relevant authorities should ensure that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions.
- Relevant authorities should, where possible, ensure that decisions are reviewed by individuals not involved in the original decision.
- Where this is not possible, relevant authorities should ensure that *at least one individual not involved in the original decision* is included in the review process. Relevant authorities must be mindful of who would be appropriate for this role in the event of representation being made.
- Relevant authorities must allow sufficient time (5 days) and opportunity for the provider that made the representations to respond to questions from the relevant authorities.

PSR Regulations – PSR Review Panel

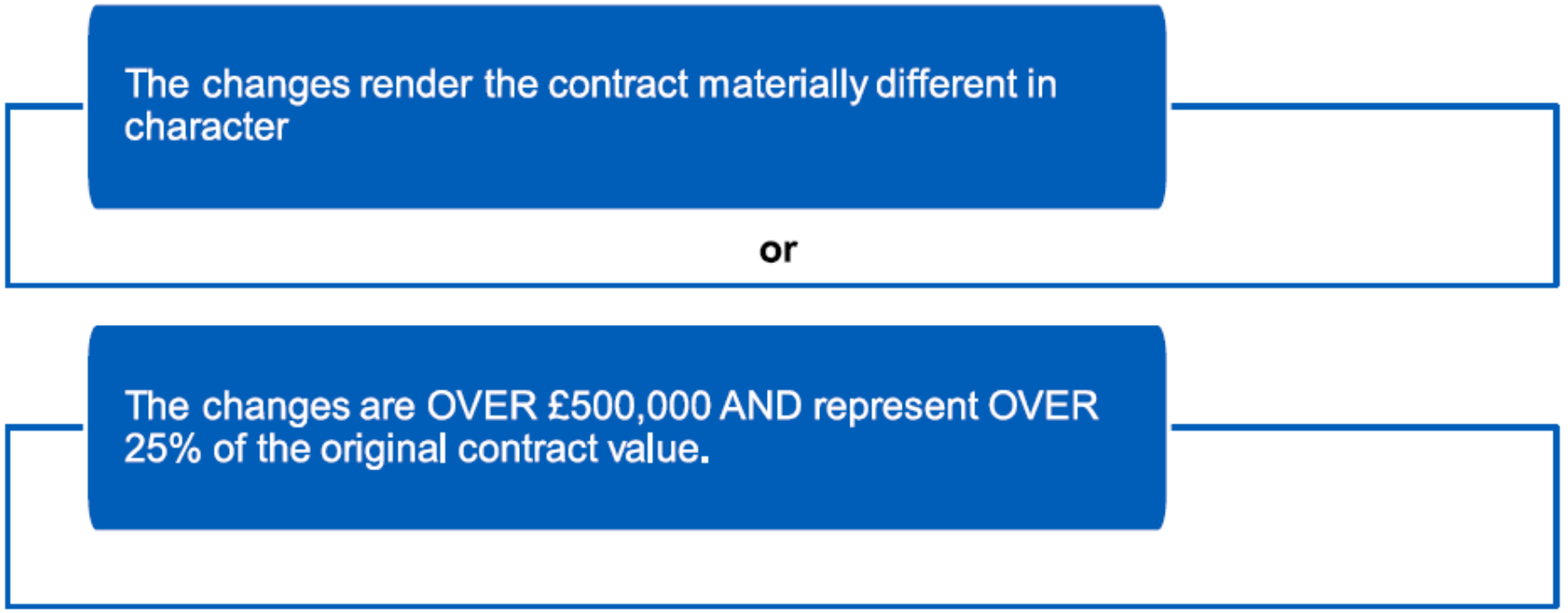
- NHS England will establish the PSR review panel to provide independent expert advice to relevant authorities.



- The relevant authority should then make a further decision about how to proceed.
- If a provider wishes to request the PSR review panel to consider their representation further, then they must submit their request through the PSR website within five working days of receiving the relevant authority's decision following the relevant authority's review of their representation.

PSR Regulations – Contract Modifications

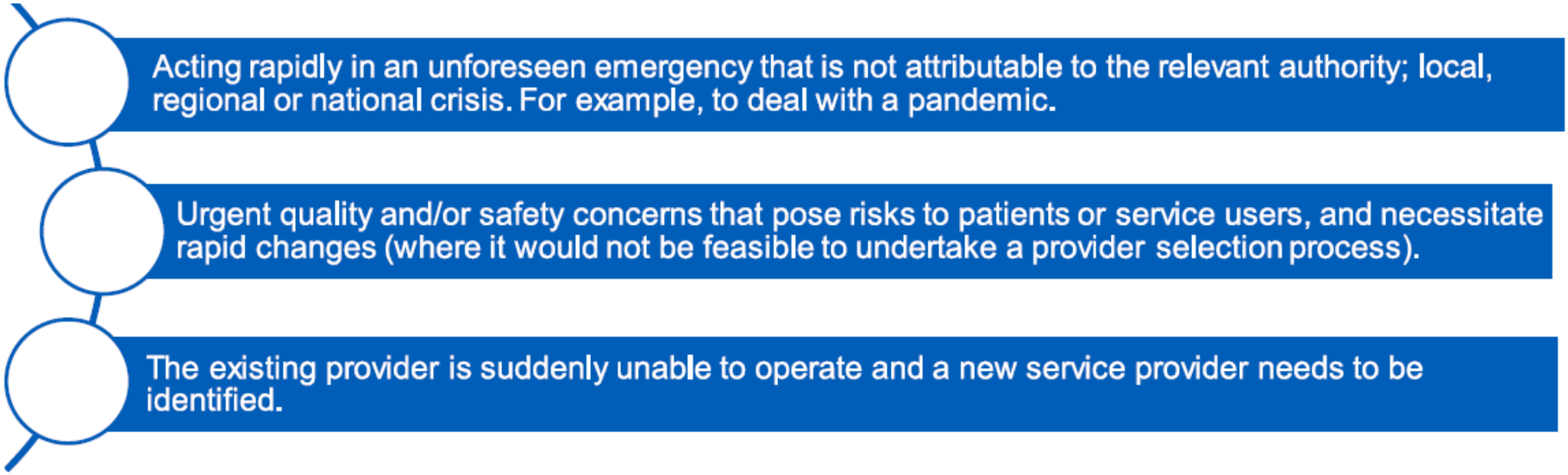
- Modifications are **not** permitted under PSR, if the modification is attributable to a decision made by the relevant authority.



- Where modifications are allowed, a transparency notice must be published.

PSR Regulations – Urgent Situations

- There are a small, limited number of occasions where relevant authorities may need to act in an emergency:



- Relevant authorities must carry a full provider selection process once the emergency has passed. If this time limit is over 12months, then a justification must be provided.

PSR Regulations – Conflicts of Interest (CoI) and Governance Arrangements

- Relevant authorities must take appropriate measures to effectively prevent, identify and remedy conflicts of interest arising during the application of the PSR.
- Relevant authorities must ensure that their governance arrangements in place for making provider selection decisions can manage conflicts and representations that may arise.
- Relevant authorities must ensure that decisions have been made in line with their governance arrangements and SFIs.
- Relevant authorities may wish to give board committees or non-executive directors (or other senior persons independent of the decision-making process) a role in managing and resolving conflicts of interest relating to provider selection decisions.

PSR Regulations – Next Steps for the ICB

- Urgent review of all contracts expiring before 31st March 2025 and those which may require an STW to maintain service continuity.
- Development of the Procurement pipeline for the next 2 years.
- Review of ICBs SFIs to align with PSR requirements.
- Review of ICB governance processes to ensure compliance with PSR requirements.
- Development of new ways of working under PSR regime.
- Staff training requirements and support leading up to and post implementation of PSR.

PSR Regulations – Resources

- NHSE have published a number of resources regarding the Provider Selection Regime, please see links below:

- Provider Selection Regime update to systems: https://www.england.nhs.uk/publication/provider-selection-regime-update-to-systems/

- The Provider Selection Regime (PSR) draft statutory guidance: https://www.england.nhs.uk/publication/the-provider-selection-regime-statutory-guidance/

- Provider Selection Regime toolkit products: https://www.england.nhs.uk/publication/provider-selection-regime-toolkit-products/

- Draft Provider Selection Regime 2023 Regulations The Health Care Services (Provider Selection Regime) Regulations 2023 (legislation.gov.uk)

Thank You
Any Questions?

Agenda Item 10

Appendix A - Month 5 – BLMK Performance Dashboard

Area	BLMK ICB	Threshold	Frequency	Latest Data	Achievement	Trend over last 6 data points	YTD	Ranking	Regional Average (ICB position vs region)	What does good look like
Elective Recovery	RTT - % Patients Waiting 18 Weeks or less	92%	M	Aug-23	50.67%	⇩	●	6 / 6	53.91%	High
	RTT - Number of 104+ Week Waits	0	M	Aug-23	2	⇧	●	2 / 6	4	Low
	RTT - Number of 78+ Week Waits	0	M	Aug-23	94	⇩	●	1 / 6	326	Low
	RTT - Number of 65+ Week Waits	1,364	M	Aug-23	2,173	⇩	●	2 / 6	2,857	Low
	RTT - Number of 52+ Week Waits	6,640	M	Aug-23	8,925	⇩	●	3 / 6	10,207	Low
	Diagnostics Tests - 6 Week Waits (%)	1%	M	Aug-23	37.22%	⇩	●	5 / 6	30.91%	Low
Cancer Care	Cancer - 28 Day Faster Diagnosis Standard	75%	M	Aug-23	71.20%	⇧	●	2 / 6	65.26%	High
	Cancer - 31 Day First Treatment	96%	M	Aug-23	93.30%	⇩	●	1 / 6	88.92%	High
	Cancer - 62 Day GP Referral	85%	M	Aug-23	67.46%	⇧	●	1 / 6	60.49%	High
Urgent & Emergency Care	A&E 4 hour waits	76%	M	Sep-23	74.60%	⇩	●	1 / 6	69.74%	High
	% all A&E patients spending >12hours in department from time of arrival	0%	M	Sep-23	3.55%	⇩	●			Low
	% ED Attendances that result in emergency admission		M	Sep-23	26.80%	⇧		3 / 6	27.75%	High
Primary Care	Number of appointments in General Practice	439,482	M	Aug-23	452,475	⇩		6 / 6	540,657	High
	% same day appointments in General Practice		M	Aug-23	40.10%	⇩		5 / 6	42.55%	High
	% of Appointments With Health Professional Other Than GP		M	Aug-23	53.04%	⇧		5 / 6	54.87%	High
Adult Mental Health	CPA 72-Hour Follow Ups	80%	M	Jul-23	81.00%	⇧	●	3 / 6	53.14%	High
	SMI Healthchecks (Rolling 12 months)	5,732	Q	Sep-23	4,040	⇧	●			High
	Dementia Diagnosis Rate	65%	M	Aug-23	67.22%	⇧	●	1 / 6	62.04%	High
	Talking Therapies (formerly IAPT) Access	2,047	M	Jul-23	2,075	⇩	●	4 / 6	2,294	High
	Talking Therapies (formerly IAPT) Moving to Recovery	50%	M	Jul-23	48.00%	⇩	●	6 / 6	50.86%	High
	Early Intervention in Psychosis (EIP)	60%	M	Jul-23	80.00%	⇧	●	3 / 6	51.86%	High
	Inappropriate Out Of Area Bed Days	265	Q	Jun-23	790	⇩	●	1 / 6	2,016	Low
Learning Disability & Autism	Learning Disability Healthchecks (Cumulative)	33.58%	M	Sep-23	27.64%	⇧	●			High
Children and Young People (CYP) & Maternity	Number of CYP accessing mental health services (Rolling 12 months)	17,424	M	Jul-23	12,865	⇩	●	3 / 6	13,548	High
	CYP Eating Disorders - Routine	95%	M	Jul-23	91.0%	⇧	●	1 / 6	60.39%	High
	CYP Eating Disorders - Urgent	95%	M	Jul-23	N/A				22.06%	High
	Perinatal Mental Health Access (YTD)	618	M	Jul-23	410	⇩	●	5 / 6	621	High
Community Services	Urgent Community Referrals - 2 hour Standard	70.00%	M	Aug-23	92.11%	⇩	●			High
	Urgent Community Referrals – Referrals		M	Aug-23	1014	⇧				High
	Childrens Wheelchairs - % received in 18 weeks	92%	Q	Sep-23	83.33%	⇩	●			High
Quality & Safety	Infection Control - C-Difficile	12	M	Aug-23	18	⇩	●	4 / 6	12.50	Low
	Infection Control - MRSA	0	M	Aug-23	0	⇧	●	1 / 6	0.43	Low
	Infection Control - E Coli (Cumulative)	158	M	Aug-23	228	⇩		1 / 6	329	Low

Key	
Trend Arrows	
⇧	Improving
⇩	Deteriorating
⇔	No change
Achievement RAG	
	On Track
	Off Track

YTD	
●	YTD On Track
●	YTD Off Track
Regional RAG	
	ICS vs Regional Average
	ICS vs Regional Average

Agenda Item 10 Quality & Performance Report

Appendix 2 BLMK System Oversight Framework (SOF) Update – Sept 2023

BLMK ICB are currently at SOF Segmentation Level 2 (Flexible Support).
As of October 2023, the ICB has 7 metrics in the top quartile, 27 in the interquartile range and 14 in the lowest quartile. The narrative below provides an update on the lowest quartile metrics and action being taken to improve performance in these areas.

- **SO37a - Percentage of patients describing their overall experience of making a GP appointment as good and S129a % of regular GP appointments within 14 days -** Each PCN has developed a Capacity and Access Plan with a focus on improving patient experience of primary care. Several practices are participating in the national General Practice Improvement Programme. Full use of ARRS, Transition to Cloud Telephony and additional investment in primary care estates to grow capacity all supporting.

- **S41a – C.diff Infection Rate** - Monthly systemwide C.diff collaborative workstream meetings. Establishing workstream for community acquired C.diff cases. Post infection review meetings continue with acute partners. Improved current position in October on C.diff numbers, reflective of improved IPC practice.

- **S042a – E-Coli Bloodstream Infection Rate** Hydration project with Bedford Hospital dietetics team is raising awareness of the risks of dehydration, UTI's and antimicrobial resistance in care homes. A collaborative BLMK wide care home study day was held with the Dietetics, IPC team and Quality improvement team. Oral Health project in care homes in partnership with Quality improvement nurses. Further work is planned with medicines/primary care on antimicrobial stewardship & use of antibiotics with a focus on reducing E-Coli.

- **SO47a - Flu vaccination uptake 65+ years** –Covid and flu vaccinations to be brought into prevention delivery plan to support better comms across primary care/at ICS level, & improved processes for monitoring performance in near real time and supporting areas of low uptake. In BLMK, 39.7% of registered 65+ population are vaccinated for flu, and 35.7% vaccinated for Covid.

- **S050a – Cervical Screening** – Recent survey sought views from women re: barriers. ICB participate in national programme using digital screens in supermarkets and at bus stops & are supporting PCNs to develop action plans at local level. Working to improve access to appts in primary care and increasing training for sample takers. Have clear plan over the next year with PCNs and the ambition is to move out of the bottom quartile in that period.

- **SO53b - Hypertension (HTN)** – Major focus on addressing HTN in primary care. ICB recently led session with 390 primary care colleagues about monitoring blood pressure (BP) in this group of patients. BLMK has launched a new HTN Management Pathway. Pilot of Florence SMS message system sends patients reminders tailored to individual needs.

- **S063a - Harassment Bullying and Abuse -** Each provider has equality and inclusion strategy and anti-racism strategy and share good practice through the system EDI group.

- **S104a – Neonatal Deaths** – Reviews through LMNS quality and safety meetings. All neonatal deaths on provider sites are reviewed using the Perinatal Mortality Review Tool. As a level 3 NICU, the Luton site has a robust process for reviewing all neonatal deaths for babies that receive care in our unit, regardless of hospital of birth. The 2021 data increase has been reviewed by local clinical experts (no exceptional cause identified) and has been discussed with the ICB.

- **S131a Perinatal Mental Health Access rate** - is exceeding trajectory in Milton Keynes but there is significant variation in the Bedford & Luton services due to staffing issues impacting capacity to offer appointments for ELFT. This has been escalated within ELFT and a remedial work plan is in place including whole service workshop (on 26th October).

Agenda Item 11 – Finance Report

Appendix A – Financial Positions of Local Authorities

Additional details regarding the financial positions of Councils can be found at the source links listed.

Bedford Borough Council
Source: 1 (bedford.gov.uk)

The table below summarises the budgetary position relevant to each Directorate.

Budget Forecast as at 30 June 2023	Current Budget	Forecast Outturn	Forecast Variance	Mitigating Actions	Revised Forecast Variance
	£ million	£ million	£ million	£ million	£ million
Adult Services	55.869	57.754	3.886	(1.136)	2.750
Children's Services	43.796	45.518	1.722	0.000	1.722
Environment	27.383	28.126	0.743	(1.695)	(0.952)
Corporate Services	20.835	26.126	5.613	0.000	5.613
Transformation	(0.553)	(0.553)	0.000	0.000	0.000
Finance	4.056	4.116	0.060	0.000	0.060
Chief Executive	3.981	4.123	0.142	0.000	0.142
Public Health	0.000	0.000	0.000	0.000	0.000
Operational Net Cost	**155.368**	**167.533**	**12.165**	**(2.831)**	**9.334**
Financing	3.082	3.105	0.023	(1.000)	(0.977)

(Revenue Trends / Executive / 13 September 2023)

Budget Forecast as at 30 June 2023	Current Budget	Forecast Outturn	Forecast Variance	Mitigating Actions	Revised Forecast Variance
	£ million	£ million	£ million	£ million	£ million
Total	**158.450**	**167.638**	**12.188**	**(3.831**	**8.357**

The forecast variance set out in this report reflects a different financial landscape to that when the 2023/2024 Budget was appro ved by Full Council in February 2023. Services are being delivered against a backdrop of continuing inflationary pressures (energy/ commodity prices and wider contract inflation) along with significant demand related pressures within Adult Social Care, Children's Social Care and Temporary Accommodation.

Key areas of variance by directorate are set out below:

Adults' Services – £1.750 million overspend.
The forecast variance within Adult Services primarily relates package costs with a net forecast overspend of £3.972 million across all external packages. This is due to several factors, namely higher than profiled package costs, an increase in levels of need, increases in the average number of hours agreed for home care packages and higher spot prices in supported living. The additional contractual cost is partially offset by client income. The forecast overspend has been offset by the use of the remaining Social Care Turbulence Reserve of £1.136 million.

In order to mitigate the forecast overspend, new high cost packages are being reviewed to confirm whether contributions from health are due to lower the impact on the Authority.

Children's Services - £1.722 million overspend.
The overspend within Children's Services is related to Looked After Children Placements of £0.652 million, costs associated with Home to School Transport of £0.533 million and employee related overspends.

The primary driver of the demand forecast overspend within Looked After Children is due to increases in the cost of placements, most notably within Semi Independent Living with a forecast overspend of £1.054 million. This is partially offset by a reduction in cost of Residential Placements due to fewer than budgeted number of placements currently required.

Home to school transport is forecast to overspend by £0.533 million. This is due to a 10% inflationary uplift in costs and a forecast 7% increase in the number of SEND pupils requiring transport from September. Work is being undertaken to review costs in an effort to reduce this forecast overspend. The chart below shows the increase in cost of home to school transport since 2019/2020.

There is a forecast overspend of £0.445 million of employee costs across the directorate primarily due to Agency staff being utilised to cover vacant Social Worker posts. Options related to the reduction in the reliance on agency staff are being developed.

Environment - £0.952 million underspend
The underspend position within Environment reflects the recommendation within this report to utilise borrowing instead of Direct Revenue Funding to fund certain schemes in the Capital Programme within Environment. This leads to a £1.695 million underspend within the directorate.

The underspend is partially offset by a number of overspends across the directorate. Within Fleet there is a forecast overspend of £0.309 million as a result of difficulties in recruitment within the team and therefore the need to outsource some of the repair work.

There is a forecast overspend within the Grounds Maintenance, Parks and Open Spaces team of £0.166 million and the forecast overspend within Refuse and Recycling of £0.159 million are due to agency staff being used to cover staff vacancies.

Parking Fee income is below budgeted levels by £0.137 million, however it should be noted that the income for the month of June was higher than budgeted, and at around pre-covid levels due to the success of events within the town centre.

Corporate Services - £5.613 million overspend
The primary reason for the overspend in Corporate Services is Temporary Accommodation which is forecast to overspend by £5.718 million. This is due to an unprecedented demand for temporary accommodation In September 2022, when the current budget was set, there were 465 households in temporary accommodation. As at June 2023 there were 658 households in temporary accommodation, an increase of 41%.

Public Health – £0.000 million over/ underspend
The public health grant allocation of £9.457 million was confirmed on 15 March 2023. This was a decrease of £0.062 million on the 2022/2023 Grant.

Overall Public Health is forecast to be on budget. Within Public Health is £0.295 million Contain Outbreak Management Fund (COMF) carried forward from 2022/2023 for work to contain Covid-19. This funding is being utilised across the Council - including targeted communications and engagement to promote protective behaviours and vaccination, grants to community and voluntary sector organisations to support Covid-19 objectives, support for rough sleeper provision as a result of Covid-19 policies, and supporting social care Covid-19 impacts.

Central Bedfordshire Council
Revenue Budget Monitoring Q1 (June) 2023/24
Source: 10.2 Item A Q1 Executive - Revenue Monitoring 2023-24.pdf (azeusconvene.com)

Executive Summary

The forecast outturn position as at June 2023 before any release of the contingency and application of grants is an overspend of £6.1M.

The forecast position after reflecting release of Contingency (£4.6M), the Household Support Fund (£1.5M) and is on budget.

The contingency for 2023/24 is £6.2M with £4.6M utilised in the forecast outturn position, thus leaving a balance of £1.6m.

The variance analysis below is after the application of the Household Support Fund (HSF) which is identified in Table 1. Please note that as at Q1, the forecast for the use of the HSF was £1.5M but it is anticipated that the full allocation of £3M will be spent in year. This will have a net nil impact on the forecast as the spend is grant funded.

- Chief Executive is forecasting on budget.
- Resources is forecasting a £0.1M overspend, which is mainly £0.4M for Legal Services, offset by higher than budgeted Housing Revenue Account recharges. The Legal Services overspend is based on trend analysis for the previous two years and due to increased complexity in cases, and court practices in connection with Children's Services casework.
- Corporate Costs is forecast on budget.
- Children's Services is forecasting an overspend of £3.0M, which relates to Educational Transport which is forecasting an overspend of £3.0M. £2.3M for SEND routes and £0.7M Mainstream routes. A new system is in the process of being implemented to provide more accurate financial information on routes. This should also mitigate some of the forecast overspend.
- Adult Social Care and Housing General Fund is forecast on budget.
- Place and Communities is forecasting an overspend of £1.6M which relates to a reduction in income from the Leisure Management Contract
- Public Health is forecasting to budget.

The table below details the full year variances by directorate:

Table 1

Directorate	Year to Date - June			Full Year			HSF	OTHER
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast Outturn £m	Variance £m	Variance £m	Variance £m
Chief Executive's	0.8	1.1	0.4	3.0	3.4	0.4	0.5	(0.1)
Resources	7.2	7.4	0.2	28.9	29.4	0.6	0.5	0.1
Corporate Costs	3.3	0.2	(3.1)	13.1	13.1	0.0	0.0	0.0
Childrens Services	14.7	18.8	4.0	59.0	62.4	3.4	0.4	3.0
SCHH	24.0	23.4	(0.6)	96.2	96.4	0.2	0.2	0.0
Place and Communities	13.2	14.6	1.4	52.0	53.6	1.6	0.0	1.6
Public Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Excl Landlord Business	**63.2**	**65.5**	**2.3**	**252.1**	**258.3**	**6.1**	**1.5**	**4.6**
HSF Grants				**0.0**	**(1.5)**	**(1.5)**	**(1.5)**	**0.0**
				252.1	**256.7**	**4.6**	**(0.0)**	**4.6**

Luton Borough Council
Source: COMMITTEE REF: (luton.gov.uk)

The first 2023-24 quarter monitoring report already depicts a challenging financial outlook with the Council facing a significant overspend at the end of the financial year. In a review of its financial position at the end of Q1, the Council is forecasting a £6.525m (Table 1 below) overspend against its £156.8m revenue budget. This position is exacerbated by a number of one off funding and underspend amounting to £4.927m resulting in a projected underlying gross core deficit of £11.452m which is net of £3m of savings delivered already.

The increase in the children's social care demand, the rise in home to school transport and the growing service demand in adult social care require urgent attention and for a robust deficit recovery plan to be put in place in order to keep the associated costs from spiralling out control. The overspend position is aggravated by the increased number of void commercial properties. The economic downturn and high cost of living are proving to be a challenge for businesses.

Table1

General Fund Departments	Approved Budget £'000	Projected Outturn £'000	Base Costs / Income Variations £'000
Airport	14	14	0
Chief Executive's	13,805	14,502	697
Children Families & Education	72,106	73,788	1,682
Inclusive Economy	51,323	52,357	1,034
Population Wellbeing	67,731	70,505	2,774
Total Services at Q1	**204,979**	**211,166**	**6,187**
General Contingencies	5,115	5,115	0
Borrowing Costs & Treasury Man.	17,922	17,833	-89
Interest on Investments	-41,804	-41,377	427
Capital Financing & Corporate Grants	-29,505	-29,505	0
Sub Total prior to transfer to/from Reserves	**156,707**	**163,232**	**6,525**
Other Specific Reserves	107	107	0
Total General Fund Overspend at Q1	**156,814**	**163,339**	**6,525**

Milton Keynes Council
Source: Q1 2023-24 Forecast Outturn Report.pdf (moderngov.co.uk)

General Fund Revenue Account (GFRA) – is currently forecasting an overspend of £4.019m. The continuing increase in demand and uncertainly around the inflation is causing pressure in year and will also continue into the Medium Term Financial Plan.

The Corporate Leadership team are currently assessing measures to address the projected overspend to ensure that this is brought back in line with the approved net budget.

The table below shows the forecast outturn position by service area. Table 1 – General Fund Forecast Outturn.

General Fund High Level Revenue Summary	P3 Position		
	2023/24 Full Year Budget	Forecast Outturn	Variance
Service	**£m's**	**£m's**	**£m's**
Adult Social Care	98.934	101.871	2.937
Public Health	12.517	12.517	0.000
Children's Services	55.640	56.731	1.091
Customer and Community	6.135	6.024	(0.111)
Strategy and Futures	0.000	0.000	0.000
Housing and Regeneration	0.000	0.000	0.000
Planning and Placemaking	2.137	2.174	0.037
Environment & Property	73.170	73.313	0.143
Resources - Retained MKC	5.196	4.902	(0.294)
Resources - Shared Services	(0.215)	(0.215)	0.000
Law & Governance	2.463	2.678	0.215
Corporate Codes & Debt Financing	18.698	18.699	0.001
Assets Management	(26.030)	(26.030)	0.000
General Fund Requirement	**248.645**	**252.664**	**4.019**
New Homes Bonus	(4.542)	(4.542)	0.000
NNDR	(72.599)	(72.599)	0.000
RSG	(6.731)	(6.731)	0.000
Public Health	(12.517)	(12.517)	0.000
Other Government Grants	(1.879)	(1.879)	0.000
Council Tax	(150.377)	(150.377)	0.000
Total Financing	**(248.645)**	**(248.645)**	**0.000**
Net Surplus / Deficit	**0.000**	**4.019**	**4.019**

A detailed variance analysis and recovery actions are included in the source link.

System Risk Register (BAF)

Generated Date	29 Nov 2023 11:47
Risk Criteria	
Project	LIVE - Risk
Risk Area	ICB Board Assurance Framework

Risk Movement Over Time (23/24)

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
BAF0001	16	16	20	20	20	20	20	20					
BAF0002	20	20	20	20	20	20	20	20					
BAF0003	20	20	20	20	20	20	20	20					
BAF0004	16	16	16	16	16	16	16	16					
BAF0005	16	16	20	20	20	20	20	20					
BAF0006	15	15	20	20	20	20	20	20					
BAF0007	16	16	16	16	16	16	16	16					
BAF0008	20	20	20	20	20	20	20	20					
BAF0009	16	16	16	16	16	16	16	16					
BAF0010			9	9	9	9	9	9					
BAF0011							16	16					

High

Prefix	Risk Detail	Initial Priority	Controls Detail	Controls Assurance Level Line of Assurance	Controls Assurance Summary	Current Priority	Actions Action Details	Target Priority
BAF0001	Risk Title: Recovery of Elective Services Risk Description: There is a risk that the NHS is unable to recover elective services and waiting times to pre-pandemic levels due to Covid and Urgent and Emergency Care pathway related pressures, workforce constraints or demand led pressures. This may lead to poorer patient outcomes and reputation damage. Risk Owner: Anne Brierley Risk Lead: Michael Ramsden Status: Open	High (4:5=20)	The actions and controls to support the Pandemic and System Pressures risk will support Elective Recovery...			High (4:5=20)	Detail: System wide transformation plan to increase productivity using GIRFT data)… Assignee: Michael Ramsden Variable Target: 28 Mar 2024 Status: In Progress	High (4:3=12)
			Processes in place to ensure those with most urgent clinical needs are treated first....	1st Line	Process embedded into clinical services for all relevant providers			
			An Elective Recovery Board has been convened to track recovery and instigate actions....	1st Line	Elective Recovery Board Papers			
			RTT reporting enabling Wait list size trends				Detail: Delivery of national and local recovery priorities, monitored through the Elective Collaboration Board and Leadership Group Assignee: Michael Ramsden Variable Target: 29 Mar 2024 Status: In Progress	
			Optimising use of available resources					
			Independent Sector and community services use to support Trusts in their wait reduction…					
			Trusts Elective recovery plans	1st Line	Ongoing monitoring and oversight via Elective Leadership Group, Elective Collaboration Board and Cancer Board			

							Detail: Protecting Electives through winter resilience Assignee: Francesca Cummings Variable Target: 15 Nov 2023 Status: Not Started	
BAF0002	Risk Title: Developing suitable workforce Risk Description: If system organisations within BLMK ICS are unable to recruit, retain, train and develop a suitable workforce then staff experience, resident outcomes and the delivery of services within the ICS, ICB People Responsibilities and the System People Plan are threatened. Risk Owner: Martha Roberts Risk Lead: Bethan Billington Status: Open	High (4:5=20)	Frequent Director of Nursing and HEE discussion on nursing workforce and future planning /risks .			High (4:5=20)	Detail: Rotational Apprenticeship: (Education Partnership) Pilot of level 3 HCA rotational apprenticeship… Assignee: Catherine Jackson Variable Target: 10 Oct 2023 Status: In Progress	High (4:3=12)
			Significant LMNS involvement and SRO ownership for maternity development - with focus on Midwifery workforce.					
			EDI & Wellbeing: People Board Sub Group focussing on supporting the wellbeing of staff across the ICS…				Detail: Launch, assess and embed the Health and Wellbeing pilot: (Primary Care) Pilot a range… Assignee: Susi Clarke Variable Target: 31 Mar 2024 Status: In Progress	
			Active workstreams around increasing placement capacity, recruitment, retention…					
			High risk areas for recruitment such as mental health, critical care and maternity have specific subgroups…					
			Leadership & OD: People Board Sub Group focussing on building the OD capacity and skills within…				Detail: 50k Nursing Target: (linked to Workforce Modelling and Supply) System has a target to increase… Assignee: Marie Lambeth-Williams Variable Target: 31 Mar 2024 Status: In Progress	
			Work ongoing to develop a workforce structure to deliver people plan and ICB workforce responsibilities					
			Primary Care: People Board Sub Group focussing on workforce programmes as they relate to Primary Care Workforce…					
			Triangulating information from Serious incidents , complaints , safeguarding …				Detail: Embed use of 'No more tick boxes' recruitment approach: (EDI & Wellbeing) … Assignee: Bethan Billington Variable Target: 31 Mar 2024 Status: Not Started	
			Workforce Modelling & Supply: People Board Sub group focussing on the development…	1st Line	People Board (occurs 2 monthly)			
			Primary Care Training Hub supporting in recruitment, retention and training of primary care workforce					
			Operational plan for 21/22 submitted. People Board receives assurances around ongoing People Plan…				Detail: Workforce Planning: Adequate integrated workforce planning approach linked to population… Assignee: John Syson Variable Target: 31 Mar 2023 Status: Complete	
			People Board: ICS Executive Group with responsibility for People Plan delivery to meet IC…					
			Education Partnership: People Board Sub Group responsible for development and co-ordination…					
BAF0003	Risk Title: System Pressure & Resilience Risk Description: As a result of continued pressure on services from various factors (staff sickness, increased activity etc) there is compromised resilience in the health and social care system which threatens delivery of services across BLMK. This may lead to poorer patient outcomes and reputational damage. Risk Owner: Anne Brierley Risk Lead: Anne Brierley Status: Open	High (4:5=20)	BLMK engaged with regional critical care groups			High (4:5=20)	Detail: BCA and MK together mobilised winter plans by October 2023 Assignee: Francesca Cummings Variable Target: 31 Oct 2023 Status: In Progress	High (3:4=12)
			BLMK Primary Care Access Program					
			SHREWD being implemented across BLMK to enable real time resilience/flow data.					
			In line with escalation process, daily system calls in place for Bedfordshire					
			Specific ICB focus on community bed management across Bedfordshire.					
			Increased Patient Transport Services to facilitate swifter discharge					
			Discharge To Assess process is being implemented in Bedfordshire (already in place in Milton Keynes and Luton)					
			Monthly reports are reviewed at the TILT, Q&P and F&P meetings and the GB	1st Line	Minutes of TILT, Q&P, F&P and GB			
			ICB officers review performance weekly via reset & restoration meetings					
			Reports are provided to the ICS CEO meeting regarding the performance issues and Covid position					
			Revised escalation process in place to prompt system response across BLMK	1st Line	Reviews of statistical performance data on monthly			

			The Exec Team reviews performance on a monthly basis		basis to are mitigations and actions			
			BLMK Performance & Delivery Group reviews performance on a bi-monthly basis and agrees system mitigations and actions					
			Work with Councils to review and redesign care pathways to release more therapy resource to focus on flow.					
			Winter Planning to include commissioning of further capacity (beds and care) across BLMK					
BAF0004	Risk Title: Widening inequalities Risk Description: There is a risk that inequalities and outcomes for specific demographic groups within BLMK population will widen (e.g. cost of living, health and care demand pressures) compromising our ICS purpose to improve outcomes and tackle inequalities. Risk Owner: Sarah Stanley Risk Lead: Sarah Stanley Status: Open	High (4:5=20)	Resource allocation for 22/23 to help to reduce inequalities and draw out learning for future investment	1st Line	Proposal signed off by appropriate governance - Paul Calaminus SRO	High (4:4=16)	Detail: Assurance and outcome metrics to be developed by Director of Contracting Assignee: Buz Dodd Variable Target: 10 Nov 2023 Status: In Progress	High (4:3=12)
			Learning from incidents , safeguarding case review, Community partnership safety work					
			The new PCN Impact Investment Fund (criteria released 24.08.21) states that by 31 March 2022, PCNswill make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	1st Line	Development of performance framework to track impact on inequalities			
			Cross-ICS inequalities steering group and working group to coordinate inequalities activity across the ICS framed around the core20plus5 approach					
			ICS system inequalities lead appointed giving more capacity for this workstream					
			Health inequalities defined at place and PCN level					
			Supporting the workforce to deal with the impact of the pandemic being overseen by the BLMK Peoples Board.					
			Work with voluntary agencies e.g maternity Voices , parent carer forums SEND in coproduction of outcomes					
			Safeguarding partnership board priorities (Neglect , transition etc..) Working with providers and partners on access for seldom heard communities					
			Developing Business Intelligence reporting to report key health outcomes/NHS constitutional standards by place and PCN…					
			Review to understand the impact of Covid on inequalities (Lloyd Denny)…					
BAF0005	Risk Title: System Transformation Risk Description: There is a risk that sustained operational pressures and complexity of change, there will be reduced delivery and benefit from strategic transformational change to deliver improved outcomes for our population. Risk Owner: Anne Brierley Risk Lead: Anne Brierley Status: Open	High (4:5=20)	Operational performance management process in place taking account of responses to operational pressures	1st Line	Operational performance management plan	High (4:5=20)	Detail: Set clear timescales and expectations for place plans to deliver transformation for the population Assignee: Anne Brierley Variable Target: 05 Sep 2023 Status: In Progress	Medium (3:2=6)
			Performance & Delivery Group - manages immediate operational issues	1st Line	Performance & Delivery Group ToRs			
			Chief Exec/SOAG - regular reviews of operational performance issues to agree mitigations	1st Line	Terms of Reference for SOAG and Chief Exec's Meeting			
			Agreed strategic priorities across the system in place					
			Same Day Urgent Primary Care Offer					
			EPRR Framework and System monitors and responds to incidents resulting from operational pressures to wider system	1st Line	EPRR Workplan			

BAF0006	Risk Title: Financial Sustainability & Underlying Financial Health Risk Description: As a result of increased inflation, significant operational pressures, patient backlogs and the enduring financial implications of the Covid pandemic - there is a risk to the underlying financial sustainability of BLMK that could result in failure to deliver statutory financial duties. Risk Owner: Dean Westcott Risk Lead: Stephen Makin Status: Open	High (5:4=20)	Monthly financial reporting to Finance & Investment Committee and Integrated Care Board - includes analysis of financial performance: revenue, capital, underlying financial performance plus risks & mitigations. System led financial oversight through SOAG, Performance & Delivery Group and System DoFs Group. Update and development of system Medium Term Financial Plan for 2023/24 to 26/27. Includes scenario modelling of key variables and downsides.			High (5:4=20)	Detail: Development and implementation of system transformation, improvement and efficiency programme covering for 2023/24 + across and between ICS partners Assignee: Anne Brierley Variable Target: 31 Jul 2023 Status: In Progress	High (4:3=12)
BAF0008	Risk Title: Population Growth Risk Description: As a result of fast rate of population growth in BLMK, there is a risk that our infrastructure will not keep pace with the needs of our population, which will exacerbate widening inequalities and outcomes. Risk Owner: Anne Brierley Risk Lead: Anne Brierley Status: Open	High (4:5=20)	Joint forward plan population trajectories Oxford-Cambridge Arc Local Authority Place Plans Partner Support Schemes for staff	1st Line	Working with public health to develop population growth and demographic shift modelling to 2040	High (4:5=20)	Detail: Primary Care estates strategy aligned with One Public Estates plan Assignee: Nicky Poulain Variable Target: 30 Apr 2024 Status: In Progress Detail: Infrastructure plans (capital, estates, health services, workforce) will be addressed.... Assignee: Anne Brierley Variable Target: 31 Dec 2023 Status: In Progress Detail: One public estates plan mapped against population growth for each borough Assignee: Dean Westcott Variable Target: 04 Dec 2023 Status: Not Started	High (3:4=12)
BAF0007	Risk Title: Climate Change Risk Description: Due to climate change and wider impacts on the environment and biodiversity, there is a significant risk of increased pressure on health and care services, due to: i) exacerbation of existing health conditions (e.g. CVD, COPD, Asthma, mental health); ii) new health challenges (e.g. tropical disease prevalence, population migrations); iii) extreme weather events resulting in harm (e.g. storms, floods, wildfires); iv) disruption to day-to-day healthcare provision (e.g. supply chain, workforce availability, power outages, infrastructure damage); and v) a deterioration in population health outcomes. This risk is materialising now, in some contexts, and will increase in both likelihood and severity as climate change progresses. Therefore the priority is to agree an Adaptation Plan for the system. Risk Owner: Maria Wogan Risk Lead: Tim Simmance Status: Open	High (4:4=16)	Partner Green Plans and Sustainability Plans. NHS organisations, local authorities and other public sector … Local Resilience Forum Adverse Weather Plans BLMK ICS Green Plan 2022-25 Severe Weather Plan Green Plan Operational Working Group Climate Adaptation Task & Finish Group			High (4:4=16)	Detail: Implement recommendations from Green Plan Health Impact assessment. Assignee: Tim Simmance Variable Target: 05 Feb 2024 Status: Not Started	Medium (2:4=8)
BAF0009	Risk Title: Rising Cost of Living Risk Description: As a result of rising cost of living there is a risk that our staff and residents will not be able meet their basic needs resulting in deteriorating physical and mental health resulting in pressure on all public services. Key concerns:- Impact of winter and cold weather- Ability to heat homes, keep warm, and eat well. Risk Owner: Maria Wogan Risk Lead: Martha Roberts Status: Open	High (4:4=16)	Delivery of ongoing communications to support population access to support services in partnership with Trusts and Local Authorities. Local Authority support schemes for residents - Warm spaces/hubs - Food banks etc Partner and national NHS financial plans for managing increased costs due to inflation			High (4:4=16)	Detail: [EDI & Wellbeing People Sub-Group established]: Ongoing work plan for maximising support for staff across BLMK. Assignee: Bethan Billington Variable Target: 31 Mar 2024 Status: In Progress	High (3:4=12)

			Clinical and operational prioritisation of waiting lists is now part of business as usual to support access to services as appropriate				Detail: Implementation of inequalities work programme to support the most vulnerable people… Assignee: Maria Laffan Variable Target: 10 Mar 2024 Status: Not Started Detail: Develop approach to prioritise residents waiting for treatment who are unable to work as a result of their condition Assignee: Tim Simmance Variable Target: 28 Jun 2024 Status: Not Started Detail: Luton 2040 programme to ensure that Luton is a healthy, fair, and sustainable town where everyone can thrive, and no one has to live in poverty. (CEO-LBC) Assignee: Nicky Poulain Variable Target: 31 Jan 2040 Status: Not Started	
BAF0011	Risk Title: Health literacy - Denny Review Risk Description: As a result of challenges with health literacy and understanding of health services as identified in the Denny Review, there is a risk that members of minority, disadvantaged and seldom-heard communities in BLMK are not able to properly access or navigate between health and care services, potentially leading to an exacerbation of health inequalities, increasing a sense of fragmentation between services, and resulting in adverse health outcomes. Risk Owner: Maria Wogan Risk Lead: Dominic Woodward-Lebihan Status: Open	High (4:4=16)	Engagement with the public via Healthwatch and VCSE to explain the differences in services available… Inequalities senior leadership group is in place Working with people and communities strategy Diverse representation on our Working with People and Communities Committee Embedding of co-production into ICB processes and operations Memorandums of Understanding with Healthwatch and with the VCSE ”Big Conversation” Programme of Work ICB’s “Decision Planner”	1st Line 2nd Line	Managed via the winter campaign Healthwatch MOU and VCSE	High (4:4=16)	Detail: Publication of ICB’s response to Denny Review setting out the ICB’s response to the issues the Review raises. Assignee: Michelle Summers Variable Target: 29 Dec 2023 Status: In Progress Detail: Co-production of "What Matters to Me" digital page to hold key information about residents across health and care Assignee: Dominic Woodward-Lebihan Variable Target: 29 Nov 2024 Status: Not Started Detail: Accessible communications produced and campaign to explain how to access health / care services Assignee: Dominic Woodward-Lebihan Variable Target: 28 Jun 2024 Status: Not Started	Medium (4:2=8)

Medium

Prefix	Risk Detail	Initial Priority	Controls Detail	Controls Assurance Level Line of Assurance	Controls Assurance Summary	Current Priority	Actions Action Details	Target Priority
BAF0010	Risk Title: Partnership working Risk Description: There is a risk that the development of the ICS’s public position on an issue is inconsistent with the public position of one or more partner member, resulting in a lack of clarity for the public and stakeholders Risk Owner: Maria Wogan Risk Lead: Dominic Woodward-Lebihan Status: Open	High (3:4=12)	Place link directors have a coordinating role at Place and lead on place relationship management for the ICB. Decision Planner gives partners notice of forthcoming decisions Engagement Planner enables system wide coordination of engagement activity Chair and CEO quarterly session with local leaders Board seminar programme Working with Communities Strategy			Medium (3:3=9)	Detail: Better promotion for joint local initiatives Assignee: Dominic Woodward-Lebihan Variable Target: 29 Mar 2024 Status: In Progress Detail: Prepare a briefing for the Deputies (op group) on the changed political landscape and what this means for in terms of OSC/HWB attendance and handling Assignee: Dominic Woodward-Lebihan Variable Target: 29 Feb 2024 Status: Not Started	Medium (3:2=6)

	Stakeholder feedback now a regular agenda item on Exec / open space agenda and at least once a week in the huddle
	Core script/key lines now includes main thematic areas of concern outlined re cllr inductions
	Exec to have an open space session on stakeholder management more generally so there is understanding of individual and collective responsibilities
	Joint representation at public events
	Integrated communications framework to enhance partnership effectiveness, which includes a weekly communications grid for systematic information sharing, a robust communications network fostering collaboration among partners, proactive engagement through partnership social media platforms, regular dissemination of the 'Live Well' newsletter to promote health and wellbeing, and the implementation of a comprehensive media and social media strategy to ensure coherent and strategic messaging across all channels

	Detail: Establishment of Place Teams as part of implementation of the Target Operating Model Assignee: Martha Roberts Variable Target: 29 Feb 2024 Status: In Progress

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Organisation: NHS Bedford Luton and Milton Keynes ICB Workforce Race Equality Standard (WRES) Report 2022 - 2023

Prepared by: AGCSU EIHR Team

Date: October 2023

Name and Title of Board Lead:

URL link on which this report and associated Action Plan will be found

Contents

Introduction

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Workforce Race Equality Standard (WRES) 2023

As of the 1st July 2022, NHS Bedfordshire Luton and Milton Keynes Clinical Commissioning Group (BLMK CCG) became NHS Bedfordshire Luton and Milton Keynes Integrated Care Board (BLMK ICB). **The workforce data and findings within this report are a snapshot of BLMK ICB on 31st March 2023 and any comparisons with last year will be an amalgamation of the previous CCG.**

The NHS Workforce Race Equality Standard (WRES) came into effect in the NHS in 2015 and was mandated for Trusts. This requirement has since changed and the WRES is now mandated for ICBs.

The purpose of the WRES is to help NHS organisations to review their equality data against 9 WRES indicators and to produce action plans which will facilitate the closure of gaps in outcomes and experience evidenced in the NHS workplace (as a whole) between White and Black and Ethnic Minority (BME) staff, as well as help to improve minority ethnic representation at Board Level.

Ultimately, it is about ensuring an inclusive approach with regards to recruitment, training and promotion.

BLMK ICB is committed to have due regard to the WRES and uses it as a force for driving change, both as an employer and Commissioner of services.

The ICB aims to fully understand the diversity of their workforce so that it can ensure non-discriminatory practice and work with staff and staff representatives to identify and eliminate barriers and discrimination in line with the Public Sector Equality Duty, the Equality Act 2010 and Employment Statutory Code of Practice.

The Action Plan sets out the actions BLMK ICB plans to undertake to fulfil its commitment to the WRES for the period 2023-2024. This has been developed, based on the WRES information the ICB has collated and analysed, while ensuring a useful and effective approach to tackling race equality across the organisation is promoted and maintained.

It is recommended that the Board of BLMK ICB notes and approves the information contained in this report and the action plan prior to publication on the ICB website.

The Nine WRES Indicators

NHS
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Integrated Care Board

To assist organisations to identify and improve ethnic minority background experiences and opportunities, they are required to collate and self-assess against nine indicators.
The nine indicators were developed in collaboration with the wider NHS. Four focus on workforce data and four are based on data from the national NHS Staff Survey questions. The last indicator focuses upon ethnic minority background representation on boards. These are detailed in the table below:

1	2	3	4	5	6	7	8	9
Workforce indicators				**National NHS Survey indicators (or equivalent)**				**Board representation indicator**
Percentage of staff in each of the AfC bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Relative likelihood of staff being appointed from shortlisting across all posts	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Relative likelihood of staff accessing non-mandatory training and CPD	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Percentage believing that the organisation provides equal opportunities for career progression or promotion	Percentage of staff who have personally experienced discrimination at work from manager/team leader or other colleagues in the last 12 months	This indicator presents the percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive and its overall workforce

Key Findings

0.5%

- 23.5% (99) of staff working in the organisation were from a black and minority ethnic background. This is a slight decrease in % terms from 24% (96) in 2022 which is close to the local BME population at 27.3%.

Regular monitoring & reviewing of workforce demographics

3.7% - 11.5%

- Clinical staff 8a-VSM: % BME staff decreased by 3.7%, and in bands 1-7 decreased by 11.5%.
- Non-clinical staff 8a-VSM: % BME staff decreased by 7% and in bands 1-7 increased by 9%.

Maintain robust inclusive recruitment and selection practices

x0.52

- The likelihood of White staff accessing non-mandatory training was 0.52 which means that BME staff were more likely to access non-mandatory training and CPD compared to their White colleagues.

Continue review of training and guidance

X2.19

- White applicants were 2.19 times more likely to be appointed from shortlisting compared to BME applicants; this shows a consistent improvement from 2021-22 at 2.31and 2020-21 which was at 2.66.

Reiteration of commitment to EIHR by leadership team

14.8%

- 14.8% of BME staff reported personally experiencing discrimination at work from a manager, team leader or other colleagues compared to 4.4% of White staff; an increase of 4.4% since 2021-22.

Promote the use of Freedom to Speak Up Guardians service

84.6%

- 84.6% of board members in NHS BLMK ICB were from a White background with 15.4% undisclosed.

Explore opportunities to further increase board diversity

86%

- 86% of the BLMK ICB workforce responded to the NHS staff survey.

Encourage staff to take part in the NHS staff survey

12.7%

- 12.7% of staff from BME background experienced harassment, bullying or abuse from patient, relative or the public compared to 8% of White staff. An increase of 2.1% since 2021.

Leadership commitment to zero tolerance policy

18.2%

- 18.2% of staff from BME background experienced harassment, bullying or abuse from other staff in the last 12 months compared to 10.4% of White colleagues. A decrease of 0.9% since 2021.

Development of Civility and Respect Toolkit

29.8%

- 29.8% of staff from a BME background believed that there were equal opportunities for career progression or promotion compared to 61.7% of White staff.

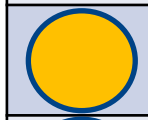
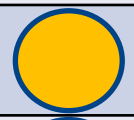
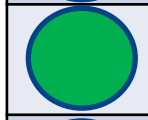
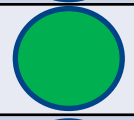
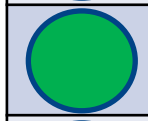
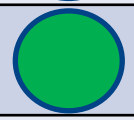
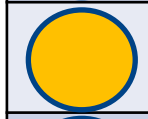
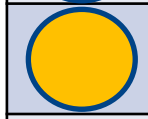
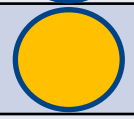
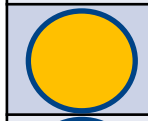
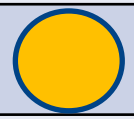
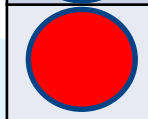
Ensure a Talent management scheme is in place

Summary of WRES

The BLMK ICB employs 421 people. Overall, 96.9 % of staff completed their ethnicity profile on ESR as of 31 March 2023; a further improvement since last year when it was at 96.5%.
As of 31 March 2023, 23.5% (99) of staff identified as BME, a reduction in percentage terms of 0.6% from 24.1% (96) in 2022.

Bedfordshire, Luton and Milton Keynes Integrated Care Board

Achieving  Developing  Under-developed 

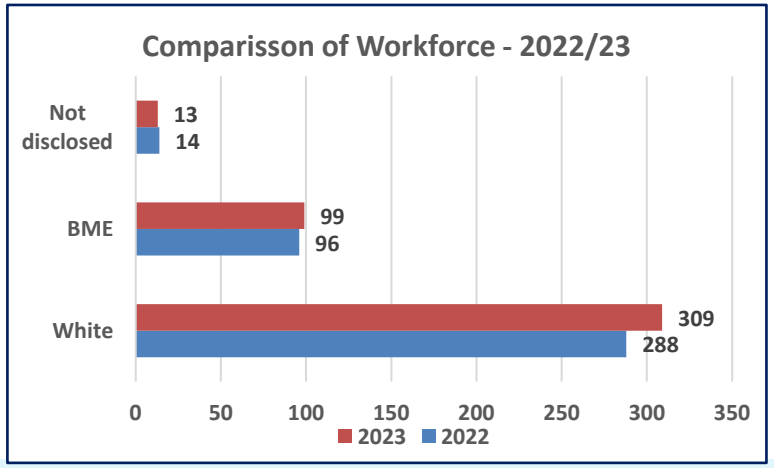
2022	2023		
		**Indicator 1**	Non-clinical: in bands 1-7 increased by 9% from 22% to 31% and in bands 8a - VSM BME representation decreased by 7%. Clinical: Bands 1 to 7 – percentage of BME staff decreased by 11.5% at 12.5% with the number of staff in this category halved from 11 to 5 and in bands 8a to VSM – number of BME staff decreased by 3.7% which represents a reduction of one colleague. The representation of BME staff is 23.5%; this short of the local population of BME community which averages at 27.3% across the ICB
		**Indicator 2**	In 2023, White candidates were 2.31 times more likely than BME candidates to be appointed from shortlisting which is a consistent year on year improvement from 2021-22 when they were 2.66 times more likely.
		**Indicator 3**	As in 2022, there were no members of BLMK staff entering the formal disciplinary process this year.
		**Indicator 4**	There has been an increase in the likelihood of BME staff accessing non-mandatory training and CPD from a likelihood of 0.81 to 0.52.
		**Indicator 5**	**Staff experiencing harassment bullying or abuse from patients, relatives or public in the last 12 months:** 12.7% of BME staff experienced this type of abuse compared with 10.6% last year; this is above the national average at 8.3%.
		**Indicator 6**	**Staff experiencing harassment, bullying or abuse from staff in last 12 months:** 18.2% of BME staff experienced this type of abuse which is below the national average at 20.6% and slightly lower than last year which was at 19.1%
		**Indicator 7**	**Staff believing that the ICB provides equal opportunities for career progression:** 29.8% of BME staff believe this to be true of the ICB which is 3.5% lower than last year and 8.5% below the national average at 38.3%.
		**Indicator 8**	**Staff personally experience discrimination at work from manager/team leader or other colleagues in the last 12 months:** 14.8% of BME staff have personally experienced discrimination which is higher than the national average at 13.3% and 4.4% higher than last year.
		**Indicator 9**	• The BLMK Board 2022/23 data, according to ESR records, show that 90.9% of the Board are White, 0% are BME and 9.1% have not disclosed their ethnicity. • At 0% the Board is not representative of the workforce population which is 23.5% BME.

Breakdown of all staff

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Staff group	2022 Number	2022 Percentage	2023 Number	2023 Percentage
BME	96	24.1%	99	23.5%
White	288	72.4%	309	73.4%
Not disclosed	14	3.5%	13	3.1%
Total	398		421	

Whilst there has been an increase in the total number of staff overall, we still need to be mindful of representation of BME staff across the workforce.



2023 local population data:

- In the ICB as a whole, the representation of BME staff is 23.5%; slightly short of the local population of BME community which averages at 27.3% across the ICB (ONS census data 2021 – 70.7% White British, 16.4% Asian, 6.9% Black , Other ethnic group 2%, Mixed or multiple ethnic group 4%).
- However, it must be noted that the there is a large variation across the population of the 4 boroughs of the ICB:
  - Bedford Borough: 22.5% BME
  - Bedford Central: 8.9% BME
  - Luton: 51.4% BME
  - Milton Keynes: 26.2% BME

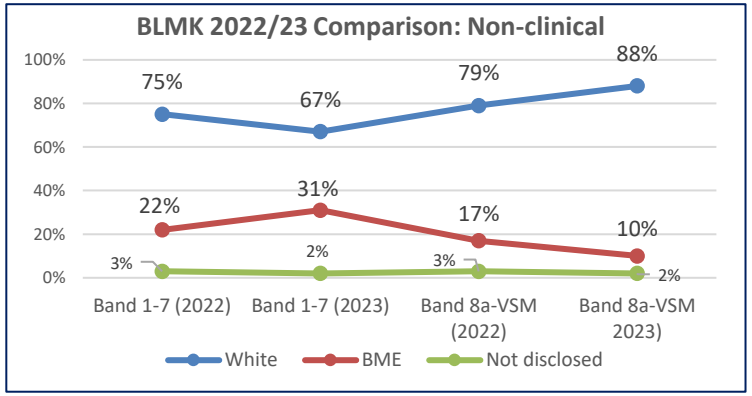
Developing

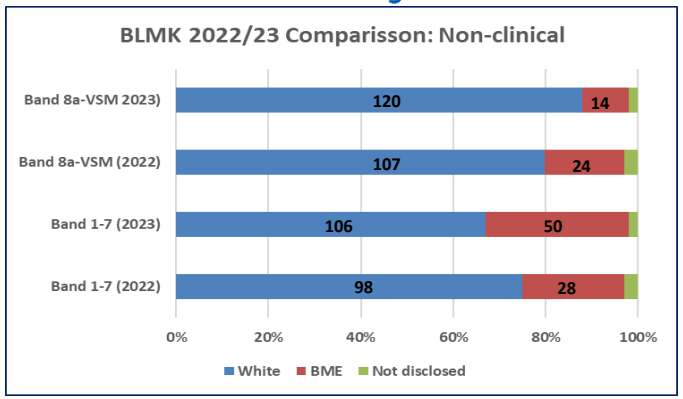
Indicator 1 – Data

Percentage of staff in AfC Bands 1-7 and 8a-VSM (including Executive Board members) in 2022 compared with the percentage of staff in the same bands in 2023. Data for clinical and non-clinical staff disaggregated.

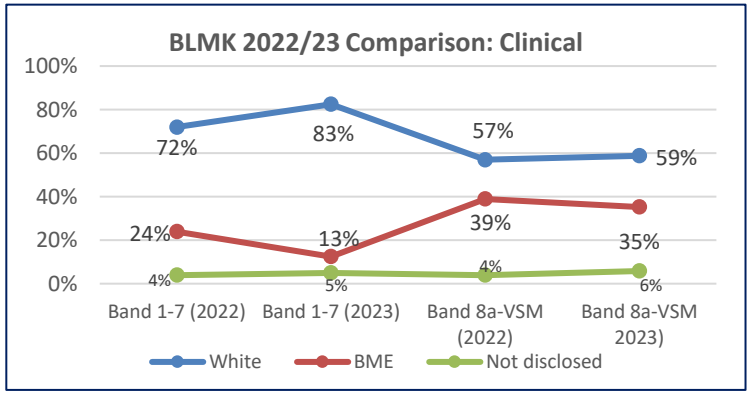
Bedfordshire, Luton and Milton Keynes Integrated Care Board

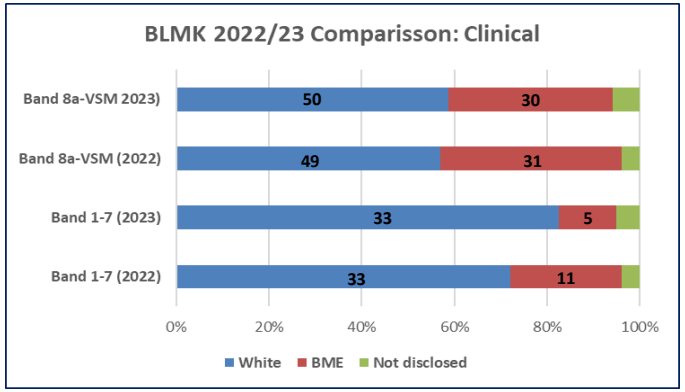
BLMK ICB 2022/23 Comparison: Non-clinical								
	Band 1 - 7 (2022)		Band 1 - 7 (2023)		Band 8a - VSM (2022)		Band 8a - VSM (2023)	
White	98	75%	106	67%	107	79%	120	88%
BME	28	22%	50	31%	24	17%	14	10%
Not disclosed	'–'	3%	'–'	2%	'–'	3%	'–'	2%
Total	130		159		135		137	





BLMK ICB 2022/23 Comparison: Clinical								
	Band 1 - 7 (2022)		Band 1 - 7 (2023)		Band 8a - VSM (2022)		Band 8a - VSM (2023)	
White	33	72%	33	82.5%	49	57%	50	58.8%
BME	11	24%	'–'	12.5%	31	39%	30	35.3%
Not disclosed	'–'	4%	'–'	5%	'–'	4%	'–'	5.9%
Total	46		40		84		85	





Where data is not available for reporting (due to numbers being at 5 or below) this is represented by '–' within the results tables.

Indicator 1

Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-Clinical Staff/Clinical staff

NHS
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Integrated Care Board

The representation of BME staff in 2023 compared with 2022 data; total workforce 421:

Non-clinical staff:

- Bands 1 to 7 - percentage of BME staff increased by 9% from 22% to 31%.
- Bands 8a to VSM - percentage of BME staff decreased by 7% from 17% to 10%.
- The number of BME staff has reduced from 24 to 14. This represents a significant loss of 52% of the number BME staff at the higher bands.
- A number of staff (less than 5) had not disclosed their ethnicity which is a slight reduction since the last report.

Action:

- It is important to understand why this significant loss has taken place at 8a-VSM level.

Clinical staff:

- Bands 1 to 7 – percentage of BME staff decreased by 11.5% at 12.5% with the number of staff in this category halved from 11 to 5.
- Bands 8a to VSM – number of BME staff decreased by 3.7% which represents a reduction of one colleague.

What is the data telling us?

- There has been an increase in the total number of staff from 407 in 2022 to 421 this year however, the proportion of BME staff has dropped by 0.6%. A higher proportion of recruitment of BME staff has been in the lower, non-clinical bands. The most marked difference is that the number of non-clinical leaders, 8a and above, has reduced by 52% from 24 to 14.
- There has been a decrease in the percentage of clinical BME staff in bands 1-7 by 11.5% with the number of staff in this category halved from 11 to 5 as well as a reduction in 3.7% which is one member of the clinical leadership team from 31 to 30.

What have we done over the last year?

- The ICB started to develop an Equality commitment pledge with accompanying acceptable behaviour statement. This commitment sets out the rights and responsibilities of staff and links to the CCG's objectives and values, which will form part of the planning for 2023-24.
- Unison Equality Charter, including duties responsibilities and behaviours in relation to EDI have been carried into the plan for 2023-24.
- The previous CCG WRES action plan was reviewed and was revised in line with this report and the regional WRES strategy.

What are we planning for 2023-24?

- This report will now utilise all previous year's results to inform the 2022-24 Action Plan which will be co-produced with representation of our staff.
- Review of data from ESR to understand why there have been these reductions in BME staff across the levels and in particular at leadership levels.
- Address gaps in ESR data by increasing declarations of ethnicity across all levels.
- Ensure that BLMK ICB remains reflective of the four places it serves through our place teams.
- Continue to monitor and review workforce demographics regularly and set appropriate/relevant improvement Key Performance Measures (KPI's) aligned to e.g. A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS

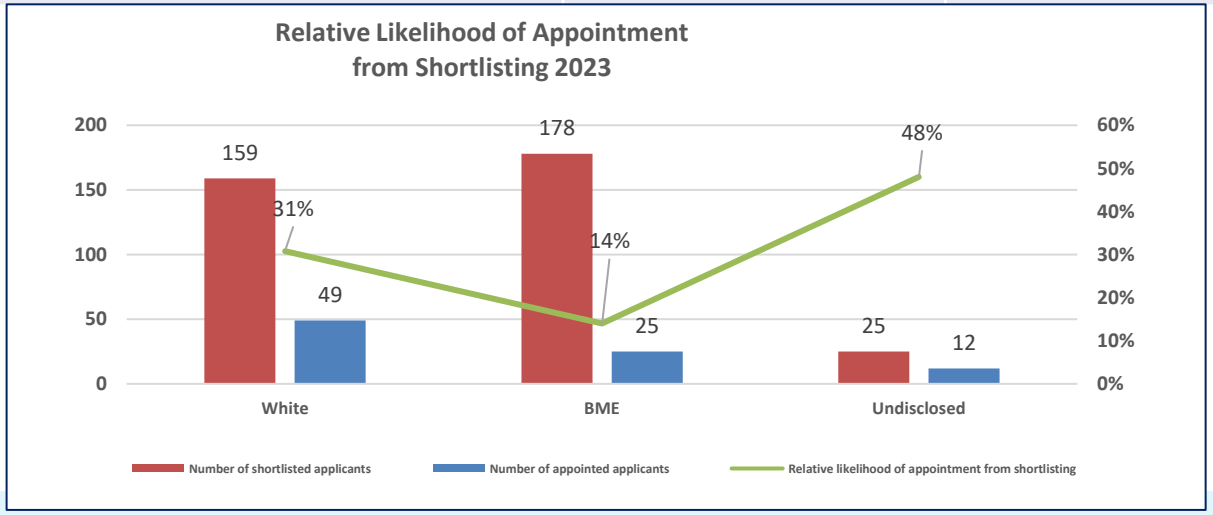
Developing

Indicator 2

Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Indicator 2: Recruitment	BLMK CCG 2022			BLMK ICB 2023		
Ethnicity	**White**	**BME**	**Not known**	**White**	**BME**	**Not known**
Number of Staff in workforce	288	96	14	309	99	13
Number shortlisted applicants	185	169	19	159	178	25
Number appointed applicants	43	17	'–'	49	25	12
Relative likelihood of appointment from shortlisting	23.2%	10.1%	10.5%	30.8%	14%	48%
Relative likelihood of White candidates being appointed from shortlisting compared to BME candidates	**2.31 times more likely**			**2.19 times more likely**		



What is the data telling us?

- The data from 2023 demonstrates that White candidates were 2.19 times more likely than BME candidates to be appointed from shortlisting.
- Although this is a consistent improvement year on year, from 2021 where the likelihood was 2.66 and 2022 was 2.31 and currently at 2.19, it is still significantly above the national average which was at 1.54 (National NHS WRES March 2022), and the desired ratio of 1:1.

What have we done over the last year?

- Masterclass held linked to our recruitment, selection and induction policies.

What are we planning for 2023-24?

- Suite of masterclasses, aligned with ICB policies to be implemented and delivered.
- Continue to monitor recruitment and retention practices to identify trends to further equalise the disproportion for BME candidates.
- Continue to ensure improvement and additional career development
- Be mindful of national targets on proportionate representation and seek to increase diversity in relevant areas of the ICB.
- Continue with recruitment training.
- Carry out a complete review of recruitment processes.
- Schedule of master classes for staff on key policies that have been reviewed, refreshed and relaunched. To start with recruitment selection and probation.
- Register the ICB with the Apprenticeship Gateway with implementation of an apprenticeship programme to support development of our workforce as well as specialised campaigns to support/attract local community into roles.

Achieving

Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

*This indicator will be based on data from a two-year rolling average of the current year and previous year.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

BLMK	2023		
Indicator 3: Disciplinary Process	White	BME	Unknown
Number of staff in workforce	309	99	13
Number of staff entering formal disciplinary	0	0	0
Likelihood of White staff entering formal disciplinary	N/A		
Likelihood of BME staff entering formal disciplinary	N/A		
The relative likelihood of BME staff entering formal disciplinary compared to White staff	N/A		

What is the data telling us?

- As with last year, there were no staff entering the formal disciplinary process this year or last year.

What have we done over the last year?

- Used effective informal processes such as one to ones to address concerns before they escalate.
- Reviewed disciplinary and grievance policy / procedures across the three previous CCG's and one single policy now in place.
- Key HR policies were reviewed and approved.
- HR policy toolkits were uploaded onto the intranet to support with understanding of policies and processes.

What are we planning for 2023-24?

- Continue to review disciplinary and grievance policy/ procedures and finalise policies for single ICB.
- Key HR policies have been reviewed and approved and a schedule of master classes for staff on these policies are to be implemented and delivered.

Achieving

Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD.

Bedfordshire, Luton and Milton Keynes Integrated Care Board

Indicator 4: Accessing non-mandatory training & CPD	NHS BLMK ICB 2022		NHS BLMK CCG 2022-2023	
Ethnicity	**White**	**BME**	**White**	**BME**
Number of Staff accessing non-mandatory training & CPD	116	48	43	24
Likelihood of staff accessing non-mandatory training & CPD	40.3%	50%	13.92%	26.97%
Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff	**0.81**		**0.52**	

What is the data telling us?

- There has been an increase in the likelihood of BME staff accessing non-mandatory training and CPD from a likelihood of 0.81 in 2022 to 0.52.
- However, figures suggest that overall, less people are accessing non-mandatory training.

What have we done over the last year?

- Carried out an initial review of the processes for self-recording non-mandatory training on ESR
- The review identified that it is possible for people to self-record, the process is straightforward, however they tend not to do so because they are unaware of this facility.

What are we planning for 2023-24?

- Communications campaign to demonstrate recording of non-mandatory training on ESR and frequent reminders to do so.
- The ICB will continue to review and implement the process for recording and reporting non-mandatory training and CPD
- Stress the importance that staff need to undertake training
- To promote and maintain NHS Elect membership to give BLMK staff access to free online courses
- Develop a blended approach and process for funded training programmes through the appraisal process.

Developing

Indicator 5-6

National NHS Staff Survey Indicators 2021/22

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Summary of September NHS National Staff Survey outcomes (WRES Indicators 5-6)	BLMK CCG 2021	BLMK ICB 2022	National Average for CCGs 2022
5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Of the total respondents (White 201 & BME 47), those who said 'Yes': **White: 10% BME: 10.6%**	Of the total respondents (White 250 & BME 55), those who said 'Yes': **White: 8% BME: 12.7%**	Of the total respondents, those who said 'Yes': **White: 7.9% BME: 8.3%**
6 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Of the total respondents (White 202 & BME 47), those who said 'Yes': **White: 12.9% BME : 19.1%**	Of the total respondents (White 250 & BME 55), those who said 'Yes': **White: 10.4% BME : 18.2%**	Of the total respondents, those who said 'Yes': **White: 15.5% BME: 20%**

Source: National NHS Staff Survey

What is the data telling us?

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months:

- The staff survey outcomes show a higher rate of such incidents than the national average for BME colleagues.
- The percentage of colleagues from a BME background experiencing such incidents increased by 2.1% from last year 10.6% to 12.7%.

6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months:

- The staff survey outcomes show a lower rate of such incidents than the national average.
- Responses from BME staff are lower than last year, though still a concern at 18.2%, and the numbers of such incidents occurring in BME staff compared to White staff is higher by 7.8%.

What have we done over the last year?

- Began to plan for and develop an EDI staff network.
- The ICB continued a zero tolerance approach to inappropriate and unacceptable behaviours, and continued the development of the Freedom to Speak Up Guardians.

What are we planning for 2023-24?

- Create awareness through staff networks and communications for staff to participate in the National NHS Staff Survey to enable benchmarking across NHS Indicators
- No formal reports of incidents - promote emerging staff networks as a useful route for staff to gain peer support which will in turn help to identify themes.
- Gain an understanding of these types of incidents being experienced by staff and why there is a disparity between the staff groups by starting to review the data already available.
- Identify ways to tackle any specific issues.
- Advertise the ICB's staff support service internally by poster and via internal facing internet / intranet pages
- Launch an anti-bullying and harassment campaign.
- Promote Freedom to Speak up Champions

Developing

Indicator 7-8

National NHS Staff Survey Indicators 2021/22

Bedfordshire, Luton and Milton Keynes Integrated Care Board

Summary of NHS National Staff Survey outcomes (WRES Indicators 7-8)	BLMK CCG 2021	BLMK ICB 2022	National Average for CCGs
7 - Percentage believing that the ICB provides equal opportunities for career progression or promotion	Of the total respondents (White 207 & BME 48), those who said 'Yes': **White: 60.9% BME: 33.3%**	Of the total respondents (White 248 & BME 57), those who said 'Yes': **White: 61.7% BME: 29.8%**	Of the total respondents those who said 'Yes': **White: 59.3% BME: 38.3%**
8 – In the last 12 months have you personally experienced discrimination at work from any of the following: Manager, Team Leader, Other Colleagues	Of the total respondents (White 210 & BME 48), those who said 'Yes': **White: 5.2% BME : 10.4%**	Of the total respondents (White 248 & BME 54), those who said 'Yes': **White: 4.4% BME : 14.8%**	Of the total respondents those who said 'Yes': **White: 4.5% BME: 13.3%**

Source: National NHS Staff Survey

What is the data telling us?

7. Percentage believing that the ICB provide equal opportunities for career progression or promotion:

- 29.8% of BME staff do believe that the organisation provides equal career opportunities for career progression or promotion.
- This is significantly (31.9%) lower than their White colleagues at 61.7% and 3.5% lower than results from last year.
- Therefore, the data tells us that a high proportion, 70.2% of BLMK BME colleagues who completed the staff survey, do not believe that they have opportunities for career progression equal to those of their White colleagues.

8. In the last 12 months, have you experienced discrimination at work from manager, team leader, or other colleagues:

- 14.8% of BME staff have experienced this type of discrimination compared to 4.4% of their White colleagues and the situation has worsened since 2021.
- In comparison with the National picture, this is 1.5% higher in BME colleagues.

What have we done over the last year?

- The ICBs Equality commitment, WRES action plan and core values of the ICB launched.
- Job and training opportunities circulated to all staff via the staff bulletin.
- NHSE East Race Equity team hosted at BLMK offices.

What are we planning for 2023-24?

- Deeper dive into why staff feel that they have been discriminated against by managers/colleagues.
- Continue with zero tolerance approach and development of Freedom to Speak Up Guardian service including introduction of FTSU Champions.
- Carry out recruitment review to look at every aspect of recruitment process and pilot a BLMK Inclusive Recruitment Toolkit to be used across the ICB to support recruiting managers.
- Create a talent management process with Head of OD across ICB and ICS, including new competencies for the ICB that reflect the organisations values.

Note: It must be recognised that the CCG's were in building up to transition to ICB and this may have affected this metric.

Underdeveloped

Indicator 9

Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

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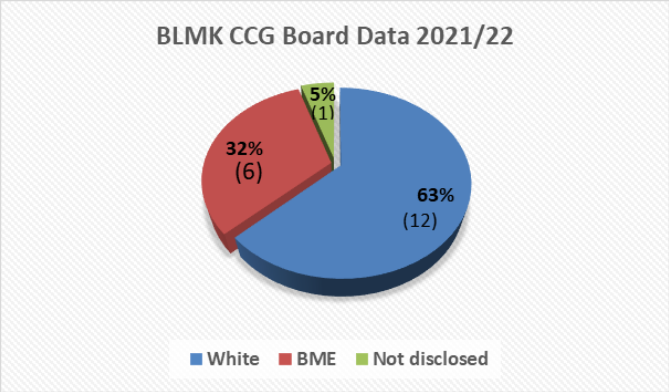
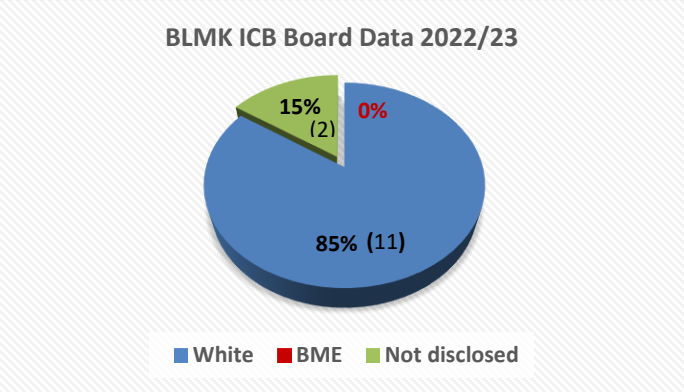
	BLMK CCG Board 2021/22					BLMK ICB Board 2022/23				
	Board		Workforce		% Difference	Board		Workforce		% Difference
White	12	63%	288	83%	**-20%**	11	84.6%	309	73.4%	**+10.6%**
BME	6	32%	96	24%	**+8%**	0	0%	99	23.5%	**-23.5%**
Not disclosed	1	5%	14	3%	**+2%**	2	15.4%	13	3.1%	**+12.3%**
Total	19		398			13		421		





What is the data telling us?
(The workforce data and findings within this report are a snapshot of BLMK ICB on 31st March 2023 and any comparisons with last year will be an amalgamation of the previous CCG.)

- The BLMK Board 2022/23 data, according to ESR records, show that 86.4% of the Board are White, 0% are BME and 15.4% have not disclosed their ethnicity.
- At 0% the Board is not representative of the workforce population which is 23.5% BME.

What have we done over the last year?

When recruiting to the Board a fair, transparent and consistent approach was taken which included working with our recruitment agency to try to attract a broad range of candidates to roles.

What are we planning for 2023-24?

- Review the processes for recording of personal information and encourage Board members to declare their ethnicity.
- The ICB will take positive steps to ensure a diverse Board that represents the population it serves in its recruitment processes and will monitor the impact of these activities.
- The development of non-exec board members planned.
- BLMK to work with the NHS Confederation, local organisations e.g. Autism Awareness, Faith Leaders, and hold community engagement events before and during recruitment processes
    - Different and varied approach to adverts
    - Drop-in sessions to be held regarding the application process.
- Continue to monitor and review Board to Workforce demographic ratio regularly and set appropriate/relevant improvement Key Performance Measures (KPI's) aligned to e.g. A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS

Source: Electronic Staff Record as at 31 March 2023

Action Plan for 2023-2024

RAG Status Key:					
	ACHIEVING		DEVELOPING		UNDERDEVELOPED

NHS England » NHS equality, diversity, and inclusion improvement plan

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Indicator	Description	Six High Impact action	RAG	Theme	Action	Outcome	Lead	Date
1, 9	1. Percentage of staff in each AfC band 1-9 or VSM compared with workforce. 9. Percentage difference between ICB Board membership and overall workforce.	High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity		Workforce Data and Quantitative Intelligence	• To carry out full review of existing information streams and the data held within them. • Review workforce data currently held to ensure it gives sufficient granularity to enhance our equality monitoring.	• Gain an insight and understand the movement of staff including the loss of BME staff at 8a-VSM level. • Use data to inform any future strategy to further improve representation of BME staff across all levels.		Review progress six monthly
2	Relative likelihood of staff being appointed from shortlisting across all posts.	High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity		Recruitment, Retention Progression	• Promote management and leadership development programs, specifically targeting employees from a BME background. These programs should provide mentoring, coaching, and training to help develop leadership skills and provide opportunities for career advancement • Establish a mentoring program: Pair senior leaders with employees from a BME background to provide guidance and support in their career development • The mentoring program should be structured and provide regular opportunities for feedback and career guidance. Promote the upcoming Transformational Reciprocal Mentoring Programme for Inclusion (BME focused) that is due to start in Autumn 2023	• Ensure recruitment processes are fair and inclusive. • Improve retention and promotion of BME staff and develop a self-reflective culture for all staff within the organisation.		
3	Relative likelihood of staff entering the formal disciplinary process.	High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.		Health and Wellbeing	• In conjunction with the Staff Partnership Forum and staff network, review existing policies such as flexible working and sickness to ensure they are inclusive.	• Ensure all policies are accessible and inclusive.		Review Quarterly
4	Relative likelihood of staff accessing non-mandatory training and CPD.	High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps		Staff Engagement	• Assess the impact of non-mandatory training on BME career progression, embedding reliable data capture by ethnicity. • Increase recording of non-mandatory training and CPD on ESR. • Develop ethnicity pay gap report. Review analysis and update key objectives based on findings	• Equal access of non-mandatory training and CPD for all staff and improved capture of this data on ESR.		Review Quarterly
5, 6,8	Percentage of staff experiencing harassment, bullying, or abuse in last 12 months from: 5. Patients, relatives, public. 6. Other staff. 8. Personally experienced from manager, lead or other colleagues.	High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.		Health and Well being	• Carry out Training Needs Analysis and analyse results in order to propose a training programme around this topic. • Linked with a new acceptable behaviours policy, once reviewed and approved; develop and implement the subsequent training programme for all staff, encouraging behavioural change by raising awareness of unconscious bias, microaggression, promoting inclusive behaviours and allyship. • Create opportunities for staff from diverse backgrounds to share their experiences and perspectives, including through staff network and engagement sessions. • Regularly review, revise, and update HR policies and procedures as appropriate to ensure that they promote inclusion and prevent discrimination. • Relaunch the Freedom to Speak up Framework for staff within the ICB. • FTSU Guardian to regularly present a report to the staff network split out against protected characteristics so that patterns can be discussed. • Launch an anti-bullying and anti-harassment campaign.	• Reduce the incidents of harassment, bullying and abuse on staff from patients' relatives, public and other colleagues. • Improved staff confidence to report such issues. • Managers more confident to provide support to staff who have experienced such incidents.		Review Quarterly
7	Percentage believing that trust provides equal opportunities for career progression or promotion.	High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.		Leadership and Culture	• Review and implement a Talent Management Programme derived from e.g. Appraisals / Training Needs Analysis with focus on ensuring fair representation and access • Programme of training to be developed for all managers on how and when to have regular caring conversations for example in 1-2-1s and appraisals as standard practice. • Encourage active membership of staff network membership to ensure that representation is reflective of the ICB's workforce profile and local population in which they work or live. Including a clear governance structure to ensure accountability and action is implemented.	• Improve percentage of staff believing that the ICB provides equal opportunities for career progression or promotion.		Review Quarterly

Contacts

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To know more

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